MHIP

Maryland Health Insurance Plan

2012 Plan Year
PPO and HDP Benefit Options
Certificate of Coverage

Effective July 1, 2012 – June 30, 2013

Administered by

CareFirst

Para información o preguntas en Español, por favor llame al número del servicio al cliente que aparece en su tarjeta de afiliación de CareFirst BlueCross BlueShield.

This document describes the essential features of the Maryland Health Insurance Plan effective July 1, 2012. This document serves as the Certificate of Coverage required under §14-505(c) of the Insurance Article and COMAR 31.17.03.13.

This Certificate of Coverage is subject to the benefits and the other terms of coverage implemented by the Board of Directors of the Maryland Health Insurance Plan.

BOK5291-1S (5/12)

MHIP PPO-HDP CERTIFICATE OF COVERAGE

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Contract with MHIP

This Certificate of Coverage (the "PPO-HDP Certificate of Coverage") states the terms and conditions for coverage of Subscribers and Members enrolled in the Preferred Provider Organization ("PPO") or High Deductible Plan ("HDP") Benefit Options offered by the Maryland Health Insurance Plan ("MHIP"). For Subscribers who have enrolled in one of the PPO Benefit Options or the HDP Benefit Option, the contract for coverage with the Plan consists of (i) this PPO-HDP Certificate of Coverage; (ii) MHIP's Master Plan, on file with the Maryland Insurance Administration ("MIA"); (iii) the MHIP Enrollment Application Form ("MHIP Application") completed by the Subscriber; and, if applicable, (iv) the Medical Questionnaire, the MHIP+ Application, and any Enrollment Coverage Change Form completed by the Subscriber. These documents constitute the entire agreement between the Subscriber and MHIP. In the event of a conflict between a provision of the Certificate of Coverage and the Master Plan, the provision most beneficial to the Subscriber or other Member controls. MHIP Plan benefits are subject to change at the discretion of the Board of Directors of the Maryland Health Insurance Plan (the "MHIP Board of Directors"). This Certificate of Coverage and MHIP's Master Plan are subject to change at the discretion of the MHIP Board of Directors by virtue of the issuance of an endorsement or amendment. The Certificate of Coverage, the Master Plan, and the terms and conditions of coverage and benefits under the Plan may not be otherwise modified. Enrollment in the Plan and any benefits through the Plan are at all times subject to Maryland law and are contingent on funding by the State of Maryland.

About This Document

This PPO-HDP Certificate of Coverage describes the Benefit Options and other features under the Plan for the PPO Benefit Options or the HDP Benefit Option. **NOTE:** MHIP and the MHIP+ Benefit Option have their own Certificates. This Certificate of Coverage contains Plan information. Each section highlights different Plan features.

- **Section One –** Plan Enrollment, Coverage Information, and Premium
- **Section Two** – Operation of the Plan and the Benefit Options
- **Section Three** – Availability and Cost of Covered Services under Each Benefit Option
- **Section Four** – Exclusions: Services Not Covered by the Plan
- **Section Five** – Member Rights and Responsibilities
- **Section Six** – Definitions

Important Terms to Know

- **Benefit Option** - Plan options authorized by the MHIP Board of Directors that include the following options described in this Certificate of Coverage:
  - ► $200 Deductible PPO (Only available to qualified MHIP+ Members)
  - ► $500 Deductible PPO
  - ► $1,000 Deductible PPO
  - ► $2,600 High Deductible Plan (HDP)
- **Covered Individual** - A Subscriber, Plan Member and/or Dependent(s)
- **Maryland Resident** - An individual who maintains his or her legal residence in the State of Maryland. Legal residence is the principal address where the individual resides, receives mail, and uses on a driver's license, any other government-issued identification card, tax returns, and any other government or important documents during the Plan Year.
- **Member** - An individual covered under the Plan.
- **Plan or MHIP** - The Maryland Health Insurance Plan.
- **Plan Administrator** - Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (also known as "CareFirst").
- **Plan Year** - The twelve (12) consecutive months beginning on July 1st and ending June 30th.
- **Subscriber** - The primary Member whose application and eligibility are the basis for participation in the Plan.
- **Type of Coverage**
  - ► **Subscriber Only** – The Plan covers only the Subscriber.
  - ► **Subscriber and Spouse** – The Plan insures the Subscriber and their spouse.
  - ► **Subscriber and Child(ren)** – The Plan covers the Subscriber and one (1) or more unmarried eligible Dependent children

► **Subscriber and Family** – The Plan will cover the Subscriber, the Subscriber's spouse, and any unmarried eligible Dependent children

Please refer to Section Six – Definitions, for other important terms.

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Important Notice

The Maryland General Assembly established a high-risk insurance pool called the Maryland Health Insurance Plan (Chapter 153, Act of 2002, as amended from time to time) to make health insurance coverage available to medically uninsurable Maryland Residents. The Plan is a State-administered health insurance program operating as an independent unit of State government. The Plan operates under the direction of the MHIP Board of Directors.

MHIP has contracted with the Plan Administrator, CareFirst BlueCross BlueShield (CareFirst), to conduct many of the day-to-day operations of the Plan, including, but not limited to, processing enrollment applications, administering Prior Authorization requests and post-service claims, arranging the Health Care Provider networks, and providing other customer and administrative services for the Plan. CareFirst provides administrative services only and does not assume any financial risk or obligation with respect to health care benefit claims.

To be eligible for coverage under the Plan, an individual must be a resident of Maryland. Should it be discovered that a Member may not be a Maryland Resident, the Member may be asked to provide indicia of residency and could be subject to termination. At no time during the investigation of a Member's residency status will coverage terminate.

ANY BENEFITS OR RIGHTS UNDER THE PLAN ARE NOT AN ENTITLEMENT, AND THE PLAN, THE MHIP BOARD OF DIRECTORS, AND THE MARYLAND GENERAL ASSEMBLY HAVE CERTAIN RIGHTS UNDER THE LAW TO REVISE, CHANGE, INTERPRET OR END THE PLAN OR ANY MEDICAL BENEFITS UNDER IT, ALL OF WHICH ARE BINDING ON EACH COVERED INDIVIDUAL. MEMBERS UNDER THE PLAN WILL BE NOTIFIED OF ANY CHANGES (AMENDMENTS) TO THE PLAN AS REQUIRED BY LAW.

Submission of Information

Included with an application, information establishing eligibility for coverage under the Plan is required. Included with an application for the MHIP+ Premium Subsidy Program, all information needed to establish eligibility for that program is required. *See* Section One, Part B – MHIP+. Once enrolled in a Plan, information supporting any claim submitted claims for Covered Services under the Plan will be required. *See* Section Two, Part M – Claim Processing. Information demonstrating continued eligibility for coverage under the Plan may be requested if and when a determination is made that such a request is warranted. If requested information is not provided, a Member may be subject to termination from the Plan. *See* Section One, Part E – End of Coverage.

Section One – Plan Enrollment, Coverage Information, and Premiums

A. When Coverage Begins and Pre-Existing Condition Limitations

Once a MHIP Application has been received, reviewed and accepted by the Plan, the Effective Date of coverage is determined as follows:

- If a completed MHIP Application is received on or before the fifteenth (15th) day of the month, the Effective Date of coverage is the first (1st) day of the following month. If a completed MHIP Application is received after the fifteenth (15th) day of the month, the Effective Date of Coverage is on the first (1st) day of the second following month.
  For example, if the Plan received a completed MHIP Application on August 14th and coverage is approved, coverage is effective on September 1st. If a completed MHIP Application is received on August 20th and approved, coverage is effective on October 1st.

OR

- If eligibility for coverage is based on rights under the Health Insurance Portability and Accountability Act ("HIPAA"), there is an option to choose between two (2) possible Effective Dates (provided the application is submitted within sixty-three (63) days from when COBRA Coverage or group coverage is exhausted): (1) a completed MHIP Application is received or COBRA Coverage or group coverage expires, whichever is later; or (2) the Effective Date outlined above based on the Plan's receipt of an application.

OR

- If an Enrollment Coverage Change Form is submitted during Open Enrollment requesting a change in a Benefit Option and the change requested is approved, the Effective Date of coverage under the new Benefit Option will be the first (1st) day of the month following Open Enrollment. **NOTE:** Benefit Option changes may only be made during Open Enrollment.

Coverage under the Plan is subject to initial and continued eligibility and payment of all Premiums.

Pre-Existing Condition Waiting Period (for Medically Eligible Individuals ONLY)
A new enrollee who has been diagnosed with or has received or been advised to receive care or treatment for a medical condition within the six (6) month period immediately prior to an Effective Date may be subject to a six (6) month Pre-Existing Condition waiting period. The Plan will not cover medical benefits for the treatment of the pre-existing medical condition for the first six (6) months a Member is covered under the Plan. The Pre-Existing Condition waiting period does not apply to Prescription Drug benefits. The Plan will notify the Member before this waiting period is imposed. This Pre-Existing Condition waiting period will not apply to the following individuals:

- An eligible individual under HIPAA as defined in § 15-1301(g) of the Insurance Article, Annotated Code of Maryland, provided the individual applies for Plan coverage within sixty-three (63) days of losing prior coverage;

- A newborn child, provided that if an additional Premium is required for the child's coverage, the child is enrolled within thirty-one (31) days after the date of birth;

- A newly adopted child, provided that if an additional Premium is required for the child's coverage, the child is enrolled within thirty-one (31) days after the date of adoption; or

- An individual who has three (3) months of prior creditable coverage is eligible for the tax credit for health insurance costs under § 35 of the Internal Revenue Code (HCTC); and applies for Plan coverage within sixty-three (63) days of losing prior creditable coverage.

If an individual applies for coverage under the Plan within sixty-three (63) days of losing prior creditable coverage, the waiting period will not apply for the period of the time the individual was covered under prior creditable coverage.

A decision by MHIP to impose a six (6) month Pre-Existing Condition waiting period constitutes a Coverage Decision as that term is defined in Section Two, Part N (Notice of Initial Decisions and Procedures for Complaints, Grievances and Appeals).

MHIP may offer a Member, subject to a six (6) month pre-existing waiting period, the opportunity to purchase an endorsement to remove the Pre-Existing Condition waiting period. **The decision to purchase the waiver of any Pre-Existing Condition waiting period must be made when the MHIP Application is submitted.** Purchasing an endorsement will require an additional Premium for the duration of twelve (12) months. If an endorsement is purchased, no Pre-Existing Condition waiting period will be imposed and the Plan will cover medical benefits for all Pre-Existing Conditions under the terms of the Benefit Option selected. MHIP will not cover the specific health condition(s) until the Member has satisfied six (6) months of creditable coverage. This coverage may be satisfied solely by virtue of being a MHIP member or with a combination of MHIP coverage and coverage the Member had during the waiting period.

NOTE: After submission of a completed MHIP Application, an endorsement to remove the Pre-Existing Condition waiting period may not be purchased.

B. MHIP+

MHIP has established an optional Premium Subsidy Program called MHIP+[**] that offers Benefit Options with reduced Premiums and expenses to MHIP Members with moderate or low household incomes (at or below 300% of the Federal Income Guidelines). An individual must be eligible for the MHIP Plan before applying for any Benefit Option under the MHIP+ program. MHIP Subscribers with an annual household income at or below certain levels may qualify for MHIP+ Benefit Options. The Benefit Options available under the MHIP+ program offer the same coverage as the standard MHIP Benefit Options, but with reduced Premiums. Some eligible MHIP+ Subscribers may also qualify for lower Deductibles and Plan expenses for Covered Services.

Applying for MHIP+
MHIP Members may apply for MHIP+ at any time. MHIP Subsidy Applications may be obtained by calling Member Services at (443) 725-1005 or toll free at (888) 678-1240, or by visiting the MHIP website at www.marylandhealthinsuranceplan.state.md.us.

After an application is submitted, MHIP will notify the individual if they are approved for a discounted MHIP+ Benefit Option. If a MHIP Subsidy Application is approved and received by the 15th of the month, the reduced premium will become effective on the 1st day of the following month. If a MHIP Subsidy Application is approved and received after the 15th of the month, the reduced premium will become effective on the 1st of the second following month.

NOTE: Premium billing may not reflect the discount for several months following approval of a MHIP+ Benefit Option. It is advised that Members continue to pay standard Premiums until receipt of notification of the new Premium amount. Credit will be given for any overpayments made after the Effective Date of the reduced premium.

MHIP+ Benefit Options
MHIP+ reduced Premium rates are available for the following Benefit Options offered by MHIP:

- **Health Maintenance Organization (HMO) Benefit Option** - Available to all current MHIP Members with household incomes at or below 300% of the Federal income guidelines. (The terms of the HMO Benefit Option are contained in a separate MHIP Certificate of Coverage.)
- **$200 Deductible Preferred Provider Organization ($200 Deductible PPO Benefit Option)** – Available to any current Member with a household income at or below 200% of the Federal income guidelines.

[**] The availability of Premium reductions and benefit enhancements under MHIP+ is based upon the availability of funds authorized by the MHIP Board. If MHIP+ enrollment and costs exceed available funding, an individual's name may be placed on a waiting list if that individual qualifies for MHIP+. Qualified waiting list applicants will be enrolled in the MHIP+ program based upon the date on which their application is received.

- **$500 Deductible Preferred Provider Organization ($500 Deductible PPO Benefit Option)** - Available to any MHIP Member with a household income that is at or below 300% of the Federal income.

Transition into MHIP+ Benefit Options and Deductibles
If a member applies and is accepted to the MHIP+ program during the Plan Year, they are only allowed to select a comparable plan. For example, an individual in a HDP plan cannot elect the HMO; an individual in a HMO cannot select a PPO. If during the Open Enrollment period the individual wants to change plans, they may do so.

MHIP+ PPO Benefit Options
Members of the PPO or HDP Benefit Options who qualify for MHIP+ and transition their enrollment to the MHIP+ $200 Deductible or $500 Deductible PPO Benefit Option will be, upon the Effective Date of the change, subject to the same rules and receive the same benefits as Members of the standard PPO Benefit Options at a reduced Premium.

- For enrollees in the $500 Deductible PPO Benefit Option who transition to the MHIP+ $500 PPO Benefit Option, all Deductibles accumulated will be credited to the $500 medical Deductible until it is met and any remaining Deductibles will be credited to the MHIP+ PPO Prescription Drug Deductible. Any remaining Deductibles will be forfeited.
- For enrollees in the $500 Deductible PPO Benefit Option who transition to the MHIP+ $200 PPO Benefit Option, all Deductibles accumulated will be credited to the medical Deductible until it is met and any remaining Deductible will be forfeited.
- For HDP Benefit Option Members who transition to the MHIP+ $500 PPO Benefit Option, all Deductibles accumulated will be credited to the medical Deductible until it is met and any remaining Deductibles will be credited to the MHIP+ PPO Prescription Drug Deductible. Any remaining Deductible will be forfeited.
- For HDP Benefit Option Members who transition to the MHIP+ $200 PPO Benefit Option, all Deductibles accumulated will be credited to the medical Deductible until it is met and any remaining Deductible will be forfeited.

NOTE: All claims for Covered Services will be considered based on the Benefit Option in which the Member is enrolled on the date of service (DOS) of the claim.

NOTE: All claims for Covered Services will be adjudicated based on the Benefit Option in which the Member is enrolled on the date of service (DOS) of the claim.

Annual Re-Qualification for MHIP +
Annually in May during the Open Enrollment process, Members enrolled in a MHIP+ Benefit Option will be required to submit a MHIP+ Re-Certification Form, a copy of their federal income tax return and any other supporting income documentation for the prior year in order to re-qualify for the MHIP+ program. If a Member no longer qualifies for MHIP+, that Member will be assigned to a comparable standard MHIP Benefit Option at the standard Premium rate.

C. Premiums

Premium Billing and Notices from the Plan
The Subscriber is the person responsible for the payment of all Premiums. All Premium billing correspondence and other Plan correspondence will be addressed to the oldest Covered Individual under the MHIP contract.

Calculation of Premiums
The MHIP Board of Directors establishes the monthly Premiums for each Benefit Option and for each MHIP+ Benefit Option for the Plan Year. Plan Premiums may be increased or decreased during the Plan Year at the sole and absolute discretion of the MHIP Board of Directors.

The monthly Premium paid during the Plan Year is determined by the following:
- The Benefit Option selected;
- The Type of Coverage selected;

- The age of the **oldest** Covered Individual under the Type of Coverage selected; and
- Whether an endorsement to remove a Pre-Existing Condition waiting period was purchased.

Payment of Premiums
Premiums are due no later than the first (1st) day of each month of coverage.

- For Members eligible for the tax credit for health insurance costs under §35 of the Internal Revenue Code (HCTC) who elect to have their tax credit advanced to the Plan from the federal government, the Premium payments due are also due no later than the first (1st) of each month.

The Plan will send notification of the amount of the Member's monthly Premium. MHIP Subscribers will receive Premium invoices on a monthly basis that will be directed to the oldest Covered Individual under the MHIP contract.

Premium payments are payable by personal check or eBilling. Checks should be made payable to **MHIP**. MHIP does not accept credit card or payments over the phone. Should a payment be submitted without a Premium statement, both the Subscriber's name and the MHIP membership number, located on the Subscriber's ID card, must be written on the check. Premium payments must be mailed to:

CareFirst TPA for State of Maryland
PO Box 791134
Baltimore, MD 21279-1134

eBilling
The Plan Administrator offers the ability to pay Premiums using the Plan Administrator's online billing system known as eBilling. A Subscriber may set up an eBilling account through *My Account* located at **www.carefirst.com/myaccount.**

With eBlling, the Subscriber is able to:

- Set up recurring (automatic debit) monthly payments with a checking account;
- View and pay their monthly Premium bill online 24 hours a day, 7 days a week;
- Check the status of a payment and any outstanding balances; and
- Submit one time payments by checking/savings account.

NOTE: The Plan, or a financial institution, may impose separate fees for payments made by check, or by automatic withdrawal from a checking account, when there are insufficient funds.

NOTE: Members eligible for the tax credit for health insurance costs under §35 of the Internal Revenue Code (HCTC) who elect to have their tax credit advanced to the Plan from the federal government are not eligible to enroll in an automatic debit plan.

Grace Period
The Grace Period is the end of the month following the date on which a Member's Premium is due.

If a Premium is paid during the Grace Period, coverage will continue under the Plan. However, if full Premium payment is not received by the last day of the month following the date on which a Premium is due, coverage will automatically terminate on the last day of the Grace Period without further advance notice. *See* Section One, Part E – End of Coverage. The Plan Administrator will send a letter if payment is not timely made.

For example, if a Premium payment is due October 1st and the Plan does not receive payment by October 31st, coverage will be terminated on October 31st.

If coverage is terminated for failure to pay the Premium during the Grace Period, the Subscriber will have a 30 day reinstatement period to pay the past due Premium plus the Premium due for month in which the reinstatement period falls to the Plan Administrator. The Plan Administrator must receive payment in full for the past due Premium plus the Premium due for month in which the reinstatement period falls prior to the expiration of the 30-

day reinstatement period. If the Subscriber fails to pay the past due Premium plus the Premium due for month in which the reinstatement period falls prior to the expiration of the 30-day reinstatement period, the Subscriber and/or any Dependents must wait one year before reapplying to the Plan. If the Plan Administrator receives payment in full for the past due Premium plus the Premium due for month in which the reinstatement period falls prior to the expiration of the 30-day reinstatement period, coverage will be reinstated for the Subscriber and/or any Dependents as of the end of the Grace Period.

Premium Adjustments
During the Plan Year, a Premium may increase because:

- The MHIP Board of Directors, at its sole and absolute discretion, increased Premium rates as required by Maryland law to keep pace with increased costs in the individual insurance market in Maryland or to maintain the solvency of the Plan.
- The age of the **oldest** Covered Individual under a MHIP contract moved from one of the following age bands to another:

  Under age 30;
  Ages 30 through 34;
  Ages 35 through 39;
  Ages 40 through 44;
  Ages 45 through 49;
  Ages 50 through 54;
  Ages 55 through 59;
  Ages 60 through 64; and
  Ages 65 and Over.

- A Member experiences a qualifying event that results in the addition or removal of a Covered Individual resulting in a change in Type of Coverage. (*See* Section One, Part D – Coverage Changes).

Any Premium change will take effect the first (1st) of the month after any Premium increase, age band change or Type of Coverage change has taken effect. The Plan will calculate the new Premium based upon the age of the **oldest** Covered Individual on a MHIP contract as of the Effective Date of the change.

D. Changes to Coverage, Plan Benefit Option, or Address

Changes to coverage or Plan Benefit Options only be made when a Qualifying Event occurs or during the Open Enrollment Period. In both situations, an Enrollment Coverage Change Form must be completed. An Enrollment Coverage Change Form may be obtained on the MHIP website at www.marylandhealthinsuranceplan.state.md.us or by contacting Member Services at (443) 725-1010 or toll free at (888) 456-2024.

NOTE: The voluntary termination of a spouse or other Dependent from other health insurance coverage is not a qualifying event, unless the end of coverage resulted from a termination from employment.

Qualifying Events

A Qualifying Event is a personal change in status which allows a Subscriber to change their benefit election. Examples of Qualifying Events include, but are not limited to:

1. Change in Marital Status – marriage, divorce, legal separation, annulment, or death of a spouse;
2. Change in Number of Dependents – birth, death, adoption, placement for adoption, award of legal guardianship;
3. Change in Employment Status of the spouse or other Dependent – A change from part-time to full-time employment, or vice versa, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in the spouse or Dependent becoming ineligible for coverage;
4. Dependent Satisfies or Ceases to Satisfy Eligibility Requirement Due to Marriage;

5. Loss of Eligibility for Payment of Premiums by a Governmental Unit Payer Plan (GUP) – If a Member is enrolled in a program under which a governmental unit pays the Member's Premium and the Member loses eligibility for that program, the Member will be terminated from the GUP. If coverage under MHIP is terminated for non-payment, the Member will have until the last day of the month during which the Premium was due (the "Grace Period") to bring the account current and be reinstated.

When a Qualifying Event occurs, a request to change to another Benefit Option must be made within thirty (30) calendar days of the Qualifying Event and any required documentation must be provided. If the request is not made in a timely manner, changes cannot be made until the next Open Enrollment period. Depending on the Qualified Event, the following documentation is required:

- Adding a spouse, due to marriage - Copy of marriage license;
- Removing a spouse, due to divorce or death – Copy of final divorce decree or death certificate;
- Adding a child (birth or adoption) – Copy of birth certificate or adoption decree. The child will be automatically covered under the Benefit Option for the first thirty-one (31) days following the event. For example, if a Member has Subscriber and spouse coverage and their child is born on January 3, 2012, the child will automatically be covered for the first thirty-one (31) days of life until February 2, 2012. If the child is added to the coverage, the Type of Coverage will change from Subscriber and Spouse to Subscriber and Family, effective January 3, 2012.
- Removing a child as a result of death or termination of parental rights – Death certificate or Affidavit relinquishing Parental Rights;
- Adding a spouse or child, because the spouse or Dependent lost other coverage because:
  - ► There was a change in employment status affecting eligibility under a previous health plan;
  - ► No longer meets eligibility criteria or has become ineligible for other coverage; or
  - ► A change in the public assistance status of a spouse or other Dependent who was receiving benefits under Medicare, Medicaid or the Maryland Children's Health Program.

  NOTE: These situations would have had to occur at the time of a Member's enrollment in the Plan.

- Loss of Eligibility for Payment of Premiums by Governmental Unit Payer Plan (GUP) - A notice from the GUP indicating ineligibility for the program under which the governmental unit paid MHIP Premiums.

Enrollment Coverage Change Forms and supporting documentation must be mailed to:

Maryland Health Insurance Plan
10455 Mill Run Circle RR-291
Owings Mills, MD 21117

Coverage changes will be made on the last day of the month in which the Plan Administrator receives the Enrollment Coverage Change Form. A Benefit Option change may not be requested at this time. Future invoices will reflect any additional premiums owed as a result of the change.

NOTE: In accordance with federal law, the Plan will provide medical coverage to certain Dependent children ("Alternate Recipients") if the Plan is directed to do so by a Qualified Medical Child Support Order (QMCSO). Generally, a QMCSO is an order or judgment from a court or produced as a result of a state-authorized administrative process directing the Plan to include a child under a Member's coverage. A QMCSO is qualified and enforceable if it specifies:

- Name and last known address;
- Each Alternate Recipient's name and address;
- A reasonable description of the coverage to which the Alternate Recipient is entitled;
- The Effective Date of Coverage
- Duration of the Alternate Recipient's entitlement to coverage; and
- Each and every health insurance plan subject to the order.

When the Plan receives a QMCSO, the Plan will promptly notify the Member that the order has been received and describe the procedures the Plan will use to determine if the order is qualified. Within a reasonable period of time, the Plan will determine whether the order is qualified and notify the Member and Alternate Recipient by mail.

Benefit Option Changes
Benefit Options cannot be changed during the Plan Year. Once enrolled in the Plan, the Benefit Option selected will remain in effect until the next Plan Year begins. A change in Benefit Options can only be made by submitting an Enrollment Coverage Change Form during the Plan's annual Open Enrollment period.

EXCEPTION: If a Member qualifies for the MHIP+ Premium Subsidy Program after enrolling in the Plan, the Member may change the Benefit Option to a MHIP+ Benefit Option for which they qualify and select. For more information about the MHIP+ program, see Section One, Part B.

Change of Address
The Plan Administrator maintains a physical and mailing address for each Member. A physical address is used to assist in the determination of Maryland residency. A mailing address is where all Plan correspondence, including enrollment or Plan informational materials, ID cards, Premium notices, and Appeal Decision letters, will be sent. These addresses may be the same. Correspondence to the Subscriber's mailing address will be addressed to the oldest Covered Individual under the Subscriber's MHIP contract.

Notification of any changes to a Member's physical and/or mailing address must be made to the Plan Administrator in writing. Notations made on Premium notices or other Plan materials will not be considered an official notification of an address change. To notify the Plan Administrator of a change to a physical and/or mailing address, a letter requesting the address change must be mailed to:

Maryland Health Insurance Plan
10455 Mill Run Circle RR-291
Owings Mills, MD 21117

E. End of Coverage

Voluntary Termination
At any time, a Subscriber may cancel coverage under this Certificate of Coverage for himself or herself and/or any Dependent(s) by sending a written request for cancellation to:

Maryland Health Insurance Plan
10455 Mill Run Circle RR-291
Owings Mills, MD 21117

Coverage will be terminated on the last day of the month in which the Plan receives the written request for cancellation. If coverage is voluntarily terminated, any Premium balance remaining after the date of termination will be refunded.

NOTE: If a Premium is due for the month in which coverage is terminated, coverage will terminate at the end of that month for nonpayment of Premium instead of being characterized as a voluntary termination. Should the Member wish to reapply to MHIP under these circumstances, the Member will be subject to the restrictions on reapplication that apply when a Member's enrollment is terminated for nonpayment of Premium. *See* Section One, Part C (Premiums).

Termination for Nonpayment of Premium
If the required Premium has not been paid, coverage for the Subscriber and/or any Dependents automatically terminates at the end of the Grace Period.

The Grace Period is end of the month after the date on which a Premium is due.

For example, if a Premium is due on September 1st and the Plan does not receive payment by September 30th, coverage will terminate on September 30th.

The Member will be mailed one (1) letter advising the Member that a Premium is due. Then,

- If the Premium is received by the Plan during the Grace Period, coverage will continue; or
- If the Premium is not received by the Plan during the Grace Period, coverage will be terminated on the last day of the month during which the Premium was due.
- Reinstatement Period. If coverage is terminated for failure to pay the Premium during the Grace Period, the Subscriber will have a 30 day reinstatement period to pay the past due Premium plus the Premium due for month in which the reinstatement period falls to the Plan Administrator. The Plan Administrator must receive payment in full for the past due Premium plus the Premium due for month in which the reinstatement period falls prior to the expiration of the 30-day reinstatement period. If the Subscriber fails to pay the past due Premium plus the Premium due for month in which the reinstatement period falls prior to the expiration of the 30-day reinstatement period, the Subscriber and/or any Dependents must wait one year before reapplying to the Plan. If the Plan Administrator receives payment in full for the past due Premium plus the Premium due for month in which the reinstatement period falls prior to the expiration of the 30-day reinstatement period, coverage will be reinstated for the Subscriber and/or any Dependents as of the end of the Grace Period.

Termination for Fraud or Misrepresentation

Coverage under the Plan will end if the Plan determines, in its discretion, that the Member and/or their Dependent(s):

- Performed an act or practice that constitutes fraud; or
- Intentionally misrepresented a material fact on the MHIP application(s) or, if applicable, the Medical Questionnaire.

If the Plan Administrator becomes aware that either of the above-mentioned circumstances may exist, the Member may be asked to provide certain documentation to the Plan. If coverage is terminated for either of the above-mentioned reasons, a termination letter will be mailed and will state the following:

- If the Plan Administrator gives notice of termination prior to the fifteenth (15th) day of the month, coverage will terminate at the end of that month; or
- If the Plan Administrator gives notice of termination on or after the fifteenth (15th) day of the month, coverage will terminate at the end of the following month.

The Plan's decision to terminate coverage for fraud or misrepresentation is a Coverage Decision and may be appealed. Procedures for filing an Appeal are outlined in Section Two, Part N – Notice of Initial Decisions and Procedures for Complaints, Grievances or Appeals.

Termination of Coverage for Ineligibility (Eligible for Substantially Similar Coverage)

Coverage under the Plan will end when a Member no longer qualifies as a Medically Uninsurable Individual under the following circumstances:

- A Member becomes covered under other coverage that is substantially similar to coverage provided by MHIP;
- A Member become eligible for coverage under Medicare, the Maryland Medical Assistance Program (Medicaid) or the Maryland Children's Health Program (MCHP); or
- A Member becomes eligible for employer-sponsored coverage that includes benefits comparable to MHIP benefits. If a Member is eligible for employer-sponsored group health insurance, but is unable to activate such coverage during a mandatory initial waiting period, the Member is still eligible for MHIP.

When information becomes available to the Plan Administrator that one or more of the above-mentioned circumstances may exist, a Member may be asked to provide documentation to the Plan.

If coverage terminates for non-eligibility based on reasons other than because a Member has become eligible for

Medicare, coverage for the Member and any of the Member's Dependents will end following notice from the Plan Administrator as follows:

- If a Member receives a termination notice from the Plan dated before the fifteenth (15th) day of the month, the termination date is the last day of the month in which the notice was sent.
- If a Member receives a termination notice from the Plan dated on or after the fifteenth (15th) day of the month, the termination date is the last day of the month following the month in which the notice was sent. For example, if the Plan notifies a Member of termination on August 14th, coverage will terminate at midnight on August 31st. If the Plan notifies a Member of termination on August 16th, coverage will terminate at midnight on September 30th.

If coverage is terminating because a Member has become eligible for Medicare, the Plan will give provide ninety (90) days' notice before terminating coverage. **NOTE:** If the Plan is notified or otherwise learns that a Member is receiving Medicare, no ninety (90) day notice will be provided and the termination date will be determined in the same manner as outlined above for all other terminations for non-eligibility.

The Plan's decision to terminate coverage for non-eligibility is a Coverage Decision and may be appealed. Procedures for filing an Appeal are outlined in Section Two, Part N – Notice of Initial Decisions and Procedures for Complaints, Grievances or Appeals.

If coverage under the Plan is terminated for non-eligibility due to a Member having substantially similar coverage, a Member's Dependent(s) may retain MHIP coverage if they are not eligible for coverage under the ineligible Member's new health coverage. In order for Dependent(s) to retain MHIP coverage, the ineligible Member must send a letter requesting continuation of coverage for the ineligible Member's Dependent(s) to:

Maryland Health Insurance Plan
10455 Mill Run Circle RR-291
Owings Mills, MD 21117

The Dependent(s)' coverage will be converted to a new contract on the first day of the month after coverage is terminated. The new Type of Coverage will be as follows:

- If only a spouse remains covered under the Plan, the spouse's new Type of Coverage will be *Subscriber Only*.
- If a spouse and children remain covered under the Plan, their new Type of Coverage will be *Subscriber and Child(ren).* If only minor Dependent children remain covered under the Plan, the new Type of Coverage will be *Subscriber Only*. If more than one child remains covered under the Plan, MHIP will give each child a separate *Subscriber Only* contract.

NOTE: The Plan must be notified if a Member or a Member's Dependent(s) have or become eligible for other coverage, including, but not limited to, employer sponsored group coverage, Medicare, Medicaid or MCHP. A Member is responsible for all Premiums for themself and their Dependents' coverage while enrolled in the Plan, regardless of eligibility, except if termination of coverage has been requested in writing. When termination of coverage is requested in writing, coverage under the Plan will terminate at the end of the month in which the termination request was received.

Termination of Coverage for Non-Eligibility (Maryland Residency)
Coverage for a Subscriber and/or their Dependent(s) for will terminate when it is determined that a Member and/or their Dependent(s) is not a Maryland Resident:

- The Plan reserves the right to ask any Subscriber and/or his/her Dependent(s) to complete a residency questionnaire. The Plan Administrator regularly reviews the physical addresses and patterns of out-of-state clams of its Members.

- When the Plan determines that the Subscriber and/or his/her Dependent(s) is not a Maryland Resident, the Plan will send its termination decision to the mailing address of the oldest Covered Individual under the Subscriber's MHIP contract.

- Termination of coverage will not take place until after the Subscriber and/or Member has exhausted his/her right to appeal the termination decision, which includes the right to a pre-termination, evidentiary hearing as provided in Section Two, Part N. The Effective Date of termination will be retroactive based on the date of notice of the Plan's original termination decision as follows:
  - ► If the Plan Administrator provided its notice of termination decision prior to the fifteenth (15th) day of the month, coverage will terminate at the end of that month; or
  - ► If the Plan Administrator provided its notice of termination decision after the fifteenth (15th) day of the month, coverage will terminate at the end of the following month.

  For example, if the Plan provided its notice of termination decision on August 14th, coverage will terminate at midnight on August 31st. If the Plan provides notice of termination on August 16th, coverage will terminate at midnight on September 30th.

The Plan's decision to terminate coverage for non-eligibility based on Maryland residency is a Coverage Decision and may be appealed. Procedures for filing an Appeal are outlined in Section Two, Part N– Notice of Initial Decisions and Procedures for Complaints, Grievances or Appeals.

Termination of Coverage for Non-Eligibility (Age of Dependent)
Coverage for a Dependent child of a Subscriber will terminate:

- On last day of the month in which the Dependent child reaches age 26, unless the Subscriber demonstrates that the Dependent child is unable to support him or herself due to a physical or mental incapacity that existed or occurred while MHIP coverage was in effect.

The Plan's decision to terminate coverage for Dependent child for non-eligibility based on age is a Coverage Decision and may be appealed. Procedures for filing an Appeal are outlined in Section Two, Part N– Notice of Initial Decisions and Procedures for Complaints, Grievances or Appeals.

Extension of Coverage
Coverage may be extended beyond the termination date in the following circumstances:

- In the event the Member is receiving Inpatient Hospital services and admission was authorized by the Plan prior to termination of coverage, admission will continue to be covered by the Plan until the Member is discharged from the Inpatient facility or the date the Plan Administrator determines that inpatient care is no longer Medically Necessary (whichever occurs first).
- In the event the Member has a claim in progress, care related to the claim in progress will continue to be covered by the Plan until the earlier of (i) the date on which the Member is released from the care of a Provider for the condition that is the basis of the claim or the date the Plan Administrator determines that care is no longer Medically Necessary (whichever occurs first); or (ii) twelve (12) months after the date coverage terminates.

Reinstatement
Coverage may be reinstated if the termination decision, on appeal or by the Plan, is determined to have been the result of a Plan error and any outstanding Premium is paid. If reinstated, the Plan will pay for covered services incurred since the termination date, consistent with all the terms, conditions, limitations, and exclusions of the Plan. The Plan will not reinstate coverage under the following circumstances:

- If coverage under the Plan was terminated due to fraud or intentional misrepresentation; or
- If coverage under the Plan was terminated for nonpayment of Premium and the account was not made current within the Grace Period.

New Application
If coverage under the Plan terminates for any reason and reinstatement is not achieved through the Appeal process, a new application must be completed and submitted. An application for coverage will be denied if:

- Coverage under the Plan was terminated due to fraud or intentional misrepresentation; or
- Coverage under the Plan was terminated for nonpayment of Premium and application for coverage was made within twelve (12) months of the termination date. However, coverage may be reinstated if:
  - ► Coverage under other Substantially Similar Coverage was obtained within sixty-three (63) days of the termination of coverage under the Plan; and
  - ► Termination from the Substantially Similar Coverage was made for a reason other than nonpayment of Premium; and
  - ► Application for Plan coverage was made within sixty-three (63) days of being terminated from the Substantially Similar Coverage.

F. Health Insurance Portability and Accountability Act (HIPAA)

Federal legislation, known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), establishes certain federal standards for the portability of health insurance coverage and the uses and disclosures of personal health information.

Right to a Certificate of Creditable Health Coverage
A right exists to receive a certificate of creditable health coverage from the Plan. When coverage under the Plan ends, the Plan Administrator will automatically issue a certificate of creditable coverage.

A copy of a certificate of creditable health coverage may be requested at any time for purposes of documenting current MHIP coverage or within the first twenty-four (24) months after coverage terminates.

A certificate of creditable health coverage may be requested by contacting Member Services at (443) 725-1010 or toll free at (888) 456-2024, or by sending a written request to:

Maryland Health Insurance Plan
10455 Mill Run Circle RR-291
Owings Mills, MD 21117

The certificate of creditable health coverage contains all the necessary information another health plan will need to determine whether prior continuous coverage should be credited toward any Pre-Existing Condition limitation period.

Disclosure of Confidential Health Information
This section contains information on the use of health information for administration and funding of the Plan, as well as Plan Member's rights.

HIPAA places restrictions on when someone may have access to personal health information. The Plan may use or personal health information for Plan administration functions, which are those activities the Plan and its Plan Administrator perform to administer MHIP.

These activities include but are not limited to:

- Determining eligibility under the Plan;
- Processing Prior Authorization or claims payment requests;
- Coordinating benefits with other coverage;
- Performing customer service; and
- Processing a Grievance or Appeal.

The Plan Administrator agrees not to use or disclose personal health information for purposes other than Plan administrative functions, as required by law, or as authorized by a Member. The Plan Administrator will report to the MHIP Board of Directors if it uses or discloses personal health information in a manner inconsistent with these restrictions. If the Plan Administrator provides personal health information to any agents and/or subcontractors that support or provide Plan administrative functions, those agents and/or subcontractors are subject to these same restrictions.

The Plan Administrator agrees to return or destroy personal health information when it no longer needs the personal health information to perform Plan administrative functions. If this return or destruction is not feasible (such as when the Plan Administrator is required to retain health information pursuant to legal obligations), the Plan Administrator will limit further uses or disclosures of personal health information to those purposes that make the return or destruction infeasible.

The Plan Administrator agrees to return or destroy personal health information when it no longer needs the personal health information to perform Plan administrative functions. If this return or destruction is not feasible (such as where the Plan Administrator is required to retain personal health information for its legal obligations), the Plan Administrator will limit further uses or disclosures of personal health information to those purposes that make the return or destruction infeasible.

A Member may authorize the Plan to disclose information to a third party by completing a Privacy Authorization Form. The Plan will limit the disclosure of such information to such third party as specified on the Privacy Authorization Form.

Section Two – Operation of the Plan and Benefit Options

A. Types of Coverage

The Plan offers four (4) Types of Coverage. The coverage selected will determine who is covered under the contract. A Type of Coverage selection may only be made (i) at the time of initial enrollment, (ii) during Open Enrollment or (iii) upon the occurrence of a qualifying event such as a change in marital status or in the number of eligible Dependents (*See* Section One, Part D – Coverage Changes).

- **Subscriber Only** – MHIP covers only the Subscriber.
- **Subscriber and Spouse** – MHIP covers the Subscriber and their spouse.
- **Subscriber and Child(ren)** – MHIP covers the Subscriber and one or more unmarried Dependent children.
- **Subscriber and Family** – MHIP covers the Subscriber, their spouse, and any unmarried Dependent children.

After qualifying for coverage under the Plan, the Subscriber may enroll themself and any eligible Dependents. A Dependent includes:

- A lawful spouse;
- An unmarried, biological child, step-child or foster child under age 26;
- A lawfully adopted, unmarried child (or child in the process of being adopted) under age 26, as of the date of placement for adoption;
- An unmarried child who is under age 26 for whom the Subscriber has been granted legal custody, including custody as a result of guardianship, other than a temporary guardianship of less than twelve (12) months duration, that is granted by a court or testamentary appointment;
- An unmarried child under age 26 for whom the Subscriber is legally obligated to provide coverage pursuant to court order, court-approved agreement, or testamentary appointment; and
- An unmarried child over age of 26, who is incapable of self-support, because of mental or physical incapacity that began prior to the age of 26 and who resides at the home of the Subscriber and relies on the Subscriber for material support.

A covered Dependent child over the age of 26 may remain enrolled, if at the time coverage would otherwise terminate:

1. The Dependent child is incapable of supporting himself or herself because of mental or physical incapacity;

2. The incapacity existed or occurred while Dependent child's coverage under the Plan was in effect;

3. The Dependent child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance; and

4. The Subscriber provides the Plan Administrator with proof of the Dependent child's medical or mental incapacity within thirty-one (31) days after the Dependent child's coverage would otherwise terminate. The Plan has the right to verify whether the child is and continues to qualify as an incapacitated Dependent child.

B. The PPO and HDP Benefit Options

This PPO-HDP Certificate of Coverage describes the following Benefit Options offered by the Plan:

- **$200 Deductible PPO (only available to certain MHIP+ qualified Members)**
- **$500 Deductible PPO**
- **$1,000 Deductible PPO**
- **$2,600 High Deductible (HDP)**

All Members on the same contract must have the same Benefit Option.

Members of any PPO Plan Benefit Option ($200 Deductible, $500 Deductible and $1,000 Deductible) or the HDP

Benefit Option may seek Covered Services from any Preferred Provider who participates in the CareFirst BlueCross BlueShield Preferred Provider network. The Allowed Benefit for the Covered Services will be provided at the in-network Coinsurance rate. Members may also seek services from any Non-Preferred Provider and the Allowed Benefit for the Covered Services will be provided at the out-of-network Coinsurance level.

Members may seek treatment from in-network Preferred Providers or out-of-network Non-Preferred Providers at will and without a referral. However, the Plan Administrator encourages each Member to establish a relationship with a principal Health Care Practitioner.

Members must pay a Deductible for medical benefits, which vary based on the Type of Coverage selected. The Deductible applies whether services are provided by a Preferred Provider or a Non-Preferred Provider. Deductibles are discussed in detail in Section Three of this Certificate. After the Deductible is met, the Plan will pay the Allowed Benefit for most Medically Necessary Covered Services, less any Coinsurance or Copayment. Annual out-of-pocket expenses for most services are capped. Each Plan Year, there is a limit to out-of-pocket expenses for Covered Services. A separate Deductible for Prescription Drug benefits may also apply.

MHIP's High Deductible Plan (HDP) is designed to permit Members to take advantage of certain tax law reforms relating to health plans. Federal law, enacted in December 2003, authorized Health Savings Accounts (HSAs), which receive favorable tax treatment by the federal government and can be used to pay for certain medical expenses of individuals enrolled in high deductible health plans. MHIP's HDP is designed to meet IRS guidelines, so that individuals who enroll in the MHIP HDP can also choose to establish an HSA to pay for certain medical and Prescription Drug out-of-pocket expenses not covered by the Plan, as permitted by the IRS.

HDP enrollees interested in HSAs must establish one through a custodial or trust account separate from MHIP. Members interested in HSAs may wish to consult their insurance, financial or tax advisor. For information about HSAs, visit the United States Department of Treasury website at http://www.treas.gov/offices/public-affairs/hsa
MHIP's three (3) PPO Benefit Options and the HDP Benefit Option each provide Prescription Drug coverage under a number of different levels of Prescription Drug Deductibles and/or Copays. Prescription Drug benefits under the PPO Benefit Options and the HDP Benefit Option are limited to a $100,000 Prescription Drug Annual Maximum per Member. *See* Section Three, Part C - Prescription Drug Program for more details.

C. Provider Information

Information about Providers in the CareFirst BlueCross BlueShield Preferred Provider network:

- Visiting the MHIP website at www.marylandhealthinsuranceplan.state.md.us and clicking on "Provider Search;"
- Contacting Member Services at (443) 725-1010 or toll free at (888) 456-2024; or
- Reviewing a printed CareFirst Provider Directory that may have been provided with enrollment materials.

NOTE: Preferred Providers participate in the CareFirst BlueCross BlueShield Preferred Provider network. Services provided by Preferred Providers will be treated as in-network. Services provided by Non-Preferred Providers will be treated as out-of-network.

D. Medical Case Management

Case management services are used for a Member with a chronic condition, a serious Illness, or complex health care needs. The Plan Administrator will initiate and perform case management services, as deemed appropriate. These services may include the following:

- Assessment of Member/family needs related to the understanding of health status and physician treatment plans, self-care and compliance capability, and continuum of care;
- Education of Member/family regarding disease, treatment compliance and self-care techniques;
- Help with organization of medical care, including arranging for needed services and supplies, as appropriate;

- Assistance in arranging for a principal or primary Health Care Provider to deliver and coordinate the Member's care and/or consultation with one or more Specialists; and
- Referrals to community resources.

E. Patient-Centered Medical Home

The capitalized terms above have the following meanings:

- Care Coordination Team - The Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.
- Care Plan - The plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.
- Health Care Provider - A physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services.
- Patient-Centered Medical Home Program ("PCMH") - Medical and associated services directed by the PCMH team of medical professionals to:
  - ► Foster the Health Care Provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;
  - ► Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and,
  - ► Exchange medical information with CareFirst, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.
- Qualifying Individual - A Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the Patient-Centered Medical Home Program.

Benefits will be provided for associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

- Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team;
- Creation and supervision of the Care Plan, inclusive of an assessment of the Qualifying Individual's medical needs;
- Education of the Qualifying Individual/family regarding the Qualifying Individual's disease, treatment compliance and self-care techniques; and
- Assistance with coordination of care, including arranging consultations with Specialists, and obtaining other Medically Necessary supplies and services, including community resources.

NOTE: Benefits provided through the PCMH Program are available only when provided by a Provider approved by the Plan Administrator who has elected to participate in the PCMH Program.

F. Prevention and Wellness Information

Periodically, information about preventative and wellness topics may be provided on the MHIP website www.marylandhealthinsuranceplan.state.md.us, or by special mailings.

G. Prior Authorization Requirements

Certain services will be covered only if Prior Authorization for a Medically Necessary service is obtained. Under the Prior Authorization procedures applicable to these Benefit Options, the Plan must approve the Covered Service in advance. The Plan conducts Utilization Review and makes Prior Authorization decisions by applying nationally recognized guidelines that apply to certain procedures and services. As described below, different Prior Authorization requirements apply to different Benefit Options.

NOTE: A Member is always responsible for obtaining Prior Authorization for any Covered Services obtained from any Out-of-Network Provider.

Prior Authorization Process
This process ensures that Hospital, Skilled Nursing Facility and Hospice Care services, certain Outpatient procedures/services and certain prescription drugs are Medically Necessary. Failure to follow the guidelines below could result in a reduction of or denial of claims for Covered Services:

Type of Service	Prior Authorization Procedure
MEDICAL	
Inpatient Hospitalization, Skilled Nursing Facility, Inpatient Hospice Care	The Provider must contact the Plan Administrator for Prior Authorization at (866) PRE-AUTH (866-773-2884).
Outpatient Procedures and Services Requiring Prior Authorization (*See* Section Two, Part G – Covered Services Requiring Prior Authorization).	The Provider must contact the Plan Administrator for Prior Authorization at (866) PRE-AUTH (866-773-2884).
Organ and Tissue Transplants	The Provider must contact the Plan Administrator for Prior Authorization at (866) PRE-AUTH (866-773-2884).
MENTAL HEALTH/SUBSTANCE ABUSE	
Inpatient Treatment at a Facility	The Provider must contact Magellan Health Services at (800) 245-7013.
Outpatient Services	The Provider must contact Magellan Health Services at (800) 245-7013.
PRESCRIPTION DRUGS	
Certain prescription drugs require preauthorization	The Provider must contact Argus Health Systems at (800) 314-2872.

For questions regarding Prior Authorization for medical services or Prescription Drugs, please contact Member Services at (443) 725-1010 or toll free at (888) 456-2024.

H. Covered Services Requiring Prior Authorization

The following Covered Services may require Prior Authorization. Preferred Providers will process Prior Authorization requirements for Members. A Member is responsible for obtaining Prior Authorization for any Covered Services obtained from any Non-Preferred Provider. **NOTE: Failure to obtain Prior Authorization, where required, could result in a reduction of or denial of claims for Covered Services. Failure or refusal to comply with Utilization Management Program requirements will result in a 50% reduction in benefits for Covered Services associated with the Member's care or treatment (other than for Medically Necessary ancillary services).**

COVERED SERVICE	PRIOR AUTHORIZATION REQUIRED?
Controlled Clinical Trials	YES
Dental Trauma	Inpatient services only
Home Health Care	YES
Hospice	YES
Hospital Inpatient admissions (all medical, surgical, rehabilitation or observation admissions)	YES
Infertility Testing and Diagnosis	YES
Mental Health and Substance Abuse Services	YES (Inpatient services only) Contact Magellan Health Services at (800) 245-7013
Oral Surgery performed at a Hospital	Inpatient services only

COVERED SERVICE	PRIOR AUTHORIZATION REQUIRED?
Organ and Tissue Transplants	YES
Prescription Drugs	Certain drugs require preauthorization
Reconstructive Surgery	Only for Inpatient services
Skilled Nursing Facility	YES

I. Emergency Services

In an Emergency, call 911 or go to the nearest Hospital Emergency Room.

The Plan will cover Emergency Services for all Members without Prior Authorization. Emergency Services are Covered Services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity, including severe pain that, in the absence of immediate medical attention, a prudent layperson that possesses an average knowledge of health and medicine could reasonably expect the condition to result in:

- Serious jeopardy to the mental or physical health of the Member;
- Danger of serious impairment of the Member's bodily functions;
- Serious dysfunction of any of the Member's bodily organs; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as the Plan Administrator determines.

If hospitalization following Emergency Services is required, a Member or their family member must notify the Plan Administrator at (866) PRE-AUTH (866-773-2884), within 48 hours or as soon as it is reasonably possible. The Health Care Provider will help to coordinate a transfer or the Plan Administrator will work with the Health Care Provider to arrange a transfer to a network Hospital when medically feasible and will also coordinate follow-up care.

J. Urgent Care

The Plan provides access to Urgent Care to all Members without Prior Authorization. Depending on the Benefit Option, an applicable Copayment or Coinsurance for Emergency Services or Urgent Care will apply. Covered Services include:

- Urgent Care at a physician's office or an Urgent Care facility;
- Emergency Services as an Outpatient or Inpatient at a Hospital (including physician services); and
- Emergency ambulance service.

The Plan will cover Urgent Care from a Preferred Provider without Prior Authorization.

K. Out-of-Area Care

Out-of-Area Services
CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Certificate of Coverage are described generally below.

Typically, Members, when accessing care outside the geographic area CareFirst serves, obtain care from Providers that have a contractual agreement (i.e., are PPO/Participating") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from Non-Participating Providers. CareFirst payment practices in both instances are described below.

Section Two – Operation of the Plan and Benefit Options

A Member will be entitled to benefits for Covered Services accessed either inside or outside the geographic area CareFirst serves. Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst's service area, e.g., Emergency Services.

Member liability for Out-of-Area Covered Emergency Services is limited to the Member Payment for Emergency Services and Urgent Care as set forth in the Certificate of Coverage. All other Covered Services will be processed at the out-of-network level of benefits.

Due to variations in Host Blue network protocols, a Member may also be entitled to benefits for some healthcare services obtained outside the geographic area CareFirst serves, even though the Member might not otherwise have been entitled to benefits if he or she had received those healthcare services inside the geographic area CareFirst serves. In no event will a Member be entitled to benefits for healthcare services, wherever he/she received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Certificate of Coverage.

A. Definitions

For purposes of Inter-Plan Programs, the underlined terms, when capitalized, are defined as follows:

Allowed Benefit, unless otherwise stated, or required by federal law, means the amount the Host Blue allows for a Covered Service regardless of whether the amount the Host Blue allows is greater or lesser than CareFirst's Allowed Benefit and is deemed a final amount.

BlueCard PPO Network Provider (PPO Provider) means a Provider who contracts with a Host Blue as part of its Preferred Provider Organization (PPO) network.

BlueCard Traditional Network Provider (Participating Provider) means a Provider who contracts with a Host Blue to be paid directly for rendering Covered Services to Members.

Non-Participating Provider means any Provider that does not contract with a Host Blue.

Preferred Provider Organization (PPO) means a healthcare benefit arrangement designed to supply services at a discounted cost by providing incentives for Members to use designated Providers (who contract with the PPO at a discount), but which also provides coverage for services rendered by Providers who are not part of the PPO network.

B. BlueCard® Program

Under the BlueCard® Program, when Members access Covered Services from a PPO Provider or Participating Provider within the geographic area served by a Host Blue, CareFirst will remain responsible to the Plan for fulfilling CareFirst contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its PPO/Participating Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Whenever a Member accesses Covered Services outside the geographic area CareFirst serves and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for the Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price CareFirst uses for a claim because they will not be applied retroactively to claims already paid.

A small number of states require Host Blues either (i) to use a basis for determining Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst would then calculate Member liability and the Plan's liability in accordance with applicable law.

Under certain circumstances, if CareFirst pays the Provider amounts that are the responsibility of the Member under this Certificate of Coverage CareFirst may collect such amounts from the Member.

C. Non-Participating Providers Outside the CareFirst Service Area

Member Liability Calculation

1. In General

When Covered Services are provided outside of the CareFirst service area by Non-Participating Providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

2. Exceptions

In some exception cases, CareFirst may pay claims from Non-Participating Providers outside of CareFirst's service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a PPO/Participating Provider, as determined by CareFirst in CareFirst's sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst may pay such claims based on the payment it would make if CareFirst were paying a Non-Contracted Provider inside of its service area, as described elsewhere in this Certificate of Coverage, where the Host Blue's corresponding payment would be more than CareFirst's in-service area Non-Contracted Provider payment, or in CareFirst's sole and absolute discretion, CareFirst may negotiate a payment with such a provider on an exception basis.

Finally, CareFirst may pay up to billed charges for the Plan's designated Covered Services.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

Inter-Plan Programs Eligibility Claim Types
Unless otherwise stated, all claim types are eligible to be processed through the Inter-Plan Programs except for those benefits that may be delivered by a third-party contracted by CareFirst to provide the specific service or services.

Out-of-Area Services	Benefit Level
Out-of-Area Covered Emergency Services	**All Inter-Plan Programs: In-Network**
	Member liability for Out-of-Area Covered Emergency Services is limited to the Member Payment for Emergency Services and Urgent Care as set forth in the Certificate of Coverage
All other Covered	**BlueCard® Program: Out-of-Network**

Services	When rendered by a BlueCard Traditional network or BlueCard PPO network provider: Member liable up to the Allowed Benefit
	Non-Participating Healthcare Providers: Out-of-Network
	Member liable up to charge (balance billing permitted)

L. Filing a Claim

Medical Claims for Preferred Providers

Members who receive Covered Services from a Preferred Provider should simply present their MHIP identification card to the Provider. The Preferred Provider takes care of filing claims for the Member. The Plan Administrator pays the Preferred Provider for Covered Services under the Plan. The Member will owe the Preferred Provider only for the services not covered by the Plan and for any applicable Deductible, Copayment, or Coinsurance.

Claims for Medical Services by Non-Preferred Providers

Members may be required to pay Non-Preferred Providers for Covered Services at the time they receive them. If a Member is required to pay for Covered Services at the time received, the Member will need to file a reimbursement claim with the Plan Administrator. Claims should be sent to the appropriate address listed under step 4 of this section. Claims will be subject to any applicable Deductible, Coinsurance or Copay. The Member has six (6) months from the date of service to submit any claim to the Plan Administrator. Failure to submit a claim within six (6) months from the date of service may result in denial of the claim.

NOTE: Non-Preferred Providers are not required to accept the Plan's Allowed Benefit as payment in full for services rendered. A Member may receive a bill from a Non-Preferred Provider for the difference between the Plan payment and the Non-Preferred Provider's billed charges.

The difference between the Allowed Benefit and Non-Preferred Provider's billed charges is not considered an eligible expense for the purposes of calculating any Deductible or Out-of-Pocket Maximum.

NOTE: Allow thirty (30) days for claim processing.

Follow the Steps Below to Submit a Claim Form for Medical or Mental Health Benefits

Step 1: Obtain a Health Benefits Claim Form

Whenever possible, request a claim form before treatment begins. Claim forms are available on the MHIP website at www.marylandhealthinsuranceplan.state.md.us on the "Forms" page or by contacting Member Services at (443) 725-1010 or toll free at (888) 456-2024.

Step 2: Complete the Health Benefits Claim Form

Complete all information requested on the claim form. Sign the claim form and attach any necessary information. Complete a separate form for each family member submitting a claim.

Step 3: Attach Related Items to the Health Benefits Claim Form

When filing a claim, submit the following information to the Plan Administrator:

- The Provider's itemized bill showing:
  - ► Letterhead stating the name and address of the person or organization providing the service;
  - ► Name of the patient receiving the service;
  - ► Date of each individual service (a range of dates is unacceptable);
  - ► Description of, and reason for, the service, including diagnostic and/or service codes; and
  - ► Charge for each individual service.
- Supporting information, as described on the Health Benefits Claim Form, is required if the claim is for the following services:

- ► Emergency or Urgent Care services;
- ► Treatment of Accidental Injury;
- ► Prescription Drugs;
- ► Prosthetic appliances and the rental or purchase of Durable Medical Equipment; or
- ► Psychotherapy.

In addition, if a Member is covered by another insurance carrier for the services for which reimbursement is sought, the explanation of benefits provided by that carrier for that service must be provided.

NOTE: If the above information does not accompany the claim form, the claim may not be processed.

Step 4: Submit the Health Benefits Claim Form
Mail the claim form and all supporting documentation to the Plan Administrator:

Mail Administrator
PO Box 14116
Lexington, KY 40512

Maintain copies of all submitted documents, including forms, bills, explanation of benefits (EOB) statements.

Pharmacy Claims for Covered Prescriptions at a Non-Participating Pharmacy
If covered prescriptions were purchased at a non-participating Pharmacy and the full cost of the Prescription Drugs was paid, file a Pharmacy claim in order to be reimbursed subject to the terms of the Plan's Prescription Drug program. The claim will be subject to any applicable Deductible or Copay. A Pharmacy claim must be submitted to the Plan Administrator within twelve (12) months from the date of service. Failure to submit a claim within twelve (12) months may result in denial of the claim.

Follow the steps below to file a Pharmacy Claim:
Step 1: Obtain a Direct Reimbursement Claim Form
Direct Reimbursement Claim Forms are available on the MHIP website at www.marylandhealthinsuranceplan.state.md.us or by contacting Member Services at (443) 725-1010 or toll free at (888) 456-2024.

Step 2: Complete the Direct Reimbursement Claim Form
To assist in processing claims for Prescription Drugs, include all information requested on the Direct Reimbursement Claim Form. Have the Pharmacy that dispensed the Prescription Drug complete the information requested in Part Three of the Direct Reimbursement Claim Form and obtain a signature on the form from a Pharmacy representative, if required. The Direct Reimbursement Claim Form must be signed and accompanied by the requested documentation.

Step 3: Attach Related Items to the Direct Reimbursement Claim Form
When filing a Pharmacy claim, submit the following documentation to Argus Health Systems. Argus Health Systems is an independent company and administers the Prescription Drug program on behalf of the Plan Administrator:

- Pharmacy receipt showing:
  - ► Date of service;
  - ► Medication received;
  - ► Rx number;
  - ► NDC Number;
  - ► Drug strength;
  - ► Number of days supplied;
  - ► Quantity received; and
  - ► Amount paid.

Submit a separate Direct Reimbursement Claim Form for each non-participating Pharmacy from which Prescription Drugs were purchased.

Step 4: Submit the Direct Reimbursement Claim Form
Mail the Direct Reimbursement Claim Form to:

Argus Health Systems
PO Box 41909
Kansas City, MO 64141

Maintain copies of all submitted documents, including forms, bills, Explanation of Benefits (EOB) statements, and receipts

M. Claim Processing

When a claim for reimbursement of Covered Services is submitted, the Plan Administrator will determine eligibility for benefits on the service date(s) and calculate the amount of benefit payable, if any. After the claim is processed, an Explanation of Benefits (EOB) statement from the Plan Administrator will be provided to the Member. This statement explains how benefits are determined, and, if appropriate, will include a reimbursement check for some or all of the charges paid for services or supplies covered by the Plan.

The Plan Administrator permits assignment of Plan benefits to any Provider whose services or supplies are the basis of the claim, or to the Member if acceptable evidence is provided to the Plan Administrator that shows the Member paid some or all costs. The Plan Administrator may, at its discretion, pay benefits directly to any Provider who provided services or supplies on which a claim is based and to whom a Member assigned receipt of payment for benefits. At the Plan's discretion, the Plan may pay benefits to the Member. Plan benefits will be paid up to the amount allowed under the Plan. When Deductibles, Coinsurance or Copays apply, it is the Member's responsibility to pay their share of those costs.

Payment of Benefits
For Covered Services under the Plan, the Allowed Benefit is based on the allowable charge for such services, as determined by the Plan. Preferred Providers accept the Plan's payment amount as payment in full *plus* any applicable Copay or Coinsurance and agree to make no additional charge for Covered Services.

Note: Non-Preferred Providers are not required to accept the Plan's Allowed Benefit as payment in full for services rendered. A bill from a Non-Preferred Provider for the difference between the Plan payment and the Provider's billed charges may be mailed to the Member.

The difference between the Allowed Benefit and Non-Preferred Provider's billed charges is not considered an eligible expense for the purposes of calculating any Deductible or Out-of-Pocket Maximum.

Facility of Payment
If the Plan Administrator determines that a claim cannot be submitted or determines that any or all charged for Health Care Services covered by the Plan were paid, because of incompetence, incapacity, or coma, the Plan Administrator may, in its sole discretion, pay Plan benefits directly to the service Provider(s) or any other individual who provides for the Member's care and support. The Plan Administrator will not be responsible for the disposition of the money so paid.

Privacy, Confidentiality, Release of Records, and Information
Any information maintained by the Plan or Plan Administrator will be treated confidentially and will not be disclosed to anyone without written authorization and consent, except as follows:

- Information will be disclosed to those who require that information to administer the Plan to confirm eligibility, coordinate treatment, authorization or to process claims and issue payments;
- Information with respect to duplicate coverage will be disclosed to the Plan or insurer that provides duplicate coverage;

- Information needed to determine if Health Care Services or supplies are Medically Necessary will be disclosed to the individual or entity consulted to assist the Plan or its designee in making those determinations; and
- Information will be disclosed as required and allowed by HIPAA, state and federal law or regulation or in response to a duly issued subpoena.

N. Notice of Initial Decisions and Procedures for Complaints, Grievances and Appeals

This portion of the Certificate describes the notification process for certain Plan decisions and the procedures for review of said decisions, including the filing of a Complaint, Grievance and/or Appeal.

These procedures replace all prior procedures issued by the Plan, which afforded Members recourse pertaining to denials and reductions of claims for benefits by the Plan.

The following table summarizes the types of decisions and their corresponding options for review:

Initial Decision	Internal Review	Decision on Review	External Review
Adverse Decision (Service Not Medically Necessary, Appropriate or Effective; Service Considered Experimental/Investigational; Cosmetic; Service Considered Cosmetic)	*Non-Emergency Case:* (May Proceed Directly to External Review for Compelling Reason)	Grievance Decision	Complaint to Maryland Insurance Commissioner
	Emergency Case: Expedited Internal Review by the Plan Designee	Grievance Decision	Complaint to Maryland Insurance Commissioner
Coverage Decision (Service Not Covered or Payment Denied or Rescission of Coverage)	*Appeal* (May Proceed Directly to External Review for Urgent Care not Already Rendered)	Appeal Decision	Complaint to Maryland Insurance Commissioner
Denial of Eligibility (Termination of Coverage for Ineligibility, Nonpayment of Premium, Fraud, Misrepresentation, or Denial of Change in Benefit Option)	*Appeal*	Appeal Decision	Complaint to Maryland Insurance Commissioner

*In the event of contemplated termination for non-eligibility based on the determination that a Member is not a Maryland resident, the Member's coverage will not terminate during the appeals process. The appeals process affords the Member the right to a pre-termination, evidentiary hearing before an impartial arbiter.

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1. DEFINITIONS

The following terms shall have the meaning ascribed to such terms whenever such terms are used in these Claims Procedures.

"Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

"Adverse Decision" means a utilization review determination that:

a. A proposed or delivered health care service covered under the Member's contract is or was not Medically Necessary, appropriate, or efficient; and

b. May result in non-coverage of the health care service. Adverse Decision does not include a Coverage Decision.

"Appeal" means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan under its internal appeal process regarding a Coverage Decision.

"Appeal Decision" means a final determination by the Plan that arises from an Appeal.

"Claim for Benefits" means a request for a Plan benefit or benefits made by a Member in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

"Claim Involving Urgent Care" means any claim for medical care or treatment that involves an Emergency Case or an Urgent Medical Condition. Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Member's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

"Claims Procedures" means, collectively, the procedures governing the filing of benefit claims, Notification of benefit determinations, and Grievances and Appeals of Adverse Benefit Determinations for Members.

"Commissioner" means the Commissioner of the Maryland Insurance Administration.

"Compelling Reason" means a showing that the potential delay in receipt of a health care service until after the Member, the Member's Representative or Health Care provider acting on behalf of the Member exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Member remaining seriously mentally ill with symptoms that cause the Member to be a danger to self or others.

"Complaint" means a protest filed with the Maryland Insurance Commissioner involving an Adverse Benefit Determination, Appeal Decision or Grievance Decision.

"Coverage Decision" means:

a. An initial determination by the Plan or the Plan's Designee that results in non-coverage of a health care service;

b. A determination by the Plan that an individual is not eligible for coverage under the Certificate of Coverage; or

c. A determination by the Plan that results in the Rescission of an individual's coverage under the Certificate of Coverage;

A Coverage Decision includes nonpayment of all or part of a Claim for Benefits. A Coverage Decision does not include an Adverse Decision or a Pharmacy Inquiry.

"Designee of the Commissioner" means any person to whom the Commissioner has delegated the authority to review and decide Complaints, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommendation or final decision.

"Emergency Case" means medical services are necessary to treat a condition or illness that, without immediate medical attention, would either (i) seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, or (ii) cause the Member to be in danger to self or others.

"Filing Date" means the earlier of:

a. Five (5) days after the date of mailing; or

b. The date of receipt.

"Grievance" means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member through the Plan's internal Grievance process regarding an Adverse Decision.

"Grievance Decision" means a final determination by the Plan that arises from a Grievance.

"Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article, Annotated Code of Maryland.

"Health Care Provider" as used in this section, means:

a. An individual who is licensed under the Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Member; or

b. A hospital as defined in Title 19 Subtitle 3 of the Health-General Article, Annotated Code of Maryland.

"Member" as used in this section, means an individual entitled to receive health care benefits under this Certificate of Coverage.

"Member's Representative" means an individual who has been authorized by a Member to file a Grievance, Appeal or a Complaint on behalf of a Member.

"Notice" or "Notification" means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

"Pharmacy Inquiry" means an inquiry submitted by a Pharmacist or Pharmacy on behalf of a Member to the Plan, Plan Designee or Pharmacy benefits manager at the point of sale about the scope of Pharmacy coverage, Pharmacy benefit design, or formulary under the Plan.

"Plan" as used in this section, means the Maryland Health Insurance Plan.

"Plan Designee," as used in this section and for purposes of these Claims Procedures, means CareFirst.

"Post-Service Claim" means any claim for a benefit that is not a Pre-Service Claim.

"Pre-Service Claim" means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"Relevant" means a document, record, or other information shall be considered relevant to a Member's claim if such document, record, or other information:

a. Was relied upon in making the benefit determination;

b. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

c. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or

d. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

"Rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions towards the cost of coverage.

"Urgent Medical Condition" means a condition that satisfies either of the following:

a. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the Plan, and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

   1) Placing the Member's life or health in serious jeopardy;

   2) The inability of the Member to regain maximum function;

   3) Serious impairment to bodily function;

   4) Serious dysfunction of any bodily organ or part; or

   5) The member remaining seriously mentally ill with symptoms that cause the Member to be a danger to self or others; or

b. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

2. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeals and Grievances of Adverse Benefit Determinations (hereinafter collectively referred to as, "Claims Procedures").

These Claims Procedures do not preclude a Member's Representative or Health Care Provider acting on behalf of a Member from acting on behalf of such Member in pursuing a Claim for Benefits, Grievance or Appeal of an Adverse Benefit Determination, or a Complaint to the Maryland Insurance Commissioner. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Adverse Benefit Determinations are made in accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Members.

For Claims in which residency is disputed while a Member is receiving benefits under the Plan and a determination is made by the Plan that the Member is not a Maryland resident, the Member may request a hearing under the process set forth in this Section, while still receiving benefits. A Member's benefits will not terminate during the appeals process when residency is the disputed eligibility criteria. An evidentiary hearing will be held before an impartial arbiter.

3. CLAIMS PROCEDURES COMPLIANCE

Failure to Follow Pre-Service Claims Procedures. In the case of a failure by a Member or a Member's Representative to follow the Plan's procedures for filing a Pre-Service Claim, the Member or representative shall be notified of the failure and the proper procedures to be followed to file a Claim for Benefits. This Notification shall be provided to the Member, the Member's Representative, or Health Care Provider acting on behalf of the Member, as appropriate, as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member.

The above shall apply only in the case of a failure that:

a. Is a communication by a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member received by the person or organizational unit designated by the Plan or Plan Designee that processes Claims for Benefits; and

b. Is a communication that names a specific Member; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

4. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

a. In general. Except as provided in paragraph 4.b below, if a claim is wholly or partially denied, the Member shall be notified in accordance with paragraph 5 herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim (for example, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or the claim is not clean and the specific information necessary for the claim to be considered a clean claim). If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Member prior to the termination of the initial thirty (30) day period. In no event shall such extension exceed a period of thirty (30) days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an

extension of time and the date by which the benefit determination will be rendered.

b. The Member shall be notified of the determination in accordance with the following, as appropriate.

1) Expedited Notification of Benefit Determinations Relating to Claims Involving Urgent Care. In the case of a Claim Involving Urgent Care, the Member shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim unless the Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Member shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph 5 herein. The Member shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

(a) Receipt of the specified information; or

(b) The end of the period afforded the Member to provide the specified additional information.

2) Concurrent Care Decisions. If an ongoing course of treatment has been approved to be provided over a period of time or for a number of treatments:

(a) Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Member shall be notified in accordance with paragraph 4.b.5) herein, of the Adverse Benefit Determination sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

(b) Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that is considered a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Member shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph 5 herein, and an Appeal shall be governed by paragraphs 6.b, 6.c and 6.d herein, as appropriate.

(c) If a health care service for a Member has been preauthorized or approved by the Plan or the Plan's Designee, the Plan may not deny reimbursement to the Health Care Provider for the preauthorized or approved service delivered to the Member unless:

(i) The information submitted regarding the service was fraudulent or intentionally misrepresentative;

(ii) Critical information required by the Plan or the Plan's Designee was omitted such that the Plan or Plan Designee's determination would have been different had it known the critical information;

(iii) A planned course of treatment for the Member was not substantially followed by the Health Care Provider; or

(iv) On the date the preauthorized service was delivered:

(1) the Member was not covered by the Plan;

(2) the Plan or the Plan's Designee maintained an automated eligibility verification system that was available to the Provider by telephone or via the Internet; and

(3) according to the verification system, the Claimant was not covered by the Plan.

(d) Continued coverage will be provided pending the outcome of an appeal.

3) Other Claims for Health Care Benefits. In the case of a claim that is not an urgent care claim or a concurrent care decision, the Member shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.

(a) *Pre-Service Claims*. In the case of a Pre-Service Claim, the Member shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim. This period may be extended one time for up to fifteen (15) days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control, and notifies the Member, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information and the Member shall be afforded at least forty five (45) days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph 5 herein.

Authorization of Pre-Service Claims. The Plan or the Plan's Designee will determine whether to authorize or certify a Pre-Service Claim within two (2) working days following receipt of all necessary information. If information needed to make a decision which was not included in the initial request for authorization or certification, the Plan or the Plan's Designee will notify the Health Care Provider within three (3) calendar days of the initial request that additional information is needed.

(b) *Post-Service Claims*. In the case of a Post-Service Claim, the Member shall be notified, in accordance with paragraph 5 herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one time for up to fifteen (15) days, provided that the Plan or the Plan's Designee determines that such an extension is necessary and notifies the Member, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary, the Plan or the Plan's Designee will send a Notice of receipt and status of the claim that states the legitimacy of the claim or the appropriate amount of reimbursement that is in dispute and whether additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or that the claim is not clean and it will specify the

additional information necessary for the claim to be considered a clean claim. The Member shall be afforded at least forty five (45) days from receipt of the Notice within which to provide the specified information.

4) Rescission Determinations. The Plan shall provide thirty (30) days advance written Notice of any proposed Rescission of coverage for any individual.

5) Calculating Time Periods. For purposes of paragraph 4 herein, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph 4.b above due to a Member's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information.

5. MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

a. This paragraph sets forth the manner and content of Notifications by the Plan of Adverse Benefit Determinations.

b. In the Case of an Adverse Decision, the Plan or the Plan's Designee shall send a Member, the Member's Representative or Health Care Provider acting on behalf of the Member written or electronic Notification of any Adverse Benefit Determination. In the case of an Adverse Decision relating to a Claim for Benefits that is not a Claim Involving Urgent Care, the Plan or the Plan's Designee shall send the written or electronic Notification within five (5) working days after the Adverse Decision has been made. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider:

1) The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount, if applicable);

2) The specific reason(s) for the Adverse Decision;

3) Reference to the specific Plan provisions on which the Adverse Decision is based;

4) A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

5) A description of the Plan's review procedures and the time limits applicable to such procedures;

6) The Plan Designee's Medical Director's name, business address and business telephone number;

7) If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision, either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or

8) If the Adverse Decision is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment

for the determination, applying the terms of the Plan to the Member's medical circumstances.

9) In the case of an Adverse Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph 4.b herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification;

10) That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within four (4) months after receipt of the Plan's Grievance Decision;

11) That a Complaint may be filed without first filing a Grievance if:

(a) The Plan notifies the Member, in writing, that it has waived the requirement that its internal grievance process be exhausted before filing a Complaint with the Commissioner;

(i) The Plan has failed to comply with any of the requirements of the internal grievance procedure described in this attachment; or

(ii) The Member, the Member's Representative or Health Care Provider acting on behalf of the Member filing a Grievance on behalf of the Member can demonstrate a Compelling Reason to do so as determined by the Commissioner;

12) The Commissioner's address, telephone number, and facsimile number;

13) A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance; and

14) The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

c. In the Case of a Coverage Decision, the Plan or the Plan Designee must, within thirty (30) calendar days, provide Member, Member's Representative, and/or the treating Health Care Provider acting on behalf of the Member a written Notice of the Coverage Decision. The statement must state in detail, in clear, understandable language, the specific factual basis for the Plan's decision and must include the following information:

1) Where applicable, the identity of the claim involved (including the date of service, the Health Care Provider and the claim amount);

2) The specific reason(s) for the Coverage Decision;

3) Reference to the specific Plan provisions on which the Coverage Decision is based;

4) A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

5) A description of the Plan's review procedures and the time limits applicable to such procedures;

6) That the Member, Member's Representative or Health Care Provider acting on behalf of the Member, has a right to file an Appeal with the Plan or the Plan's Designee;

7) In the case of a Coverage Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph 4.b herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

8) That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within four (4) months after receipt of the Plan's Appeal Decision;

9) That the Member, Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves a Claim Involving Urgent Care which has not been rendered;

10) The Commissioner's address, telephone number, and facsimile number;

11) A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing an Appeal; and

12) The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

d. Adverse Benefit Determinations are made under the direction of the Plan Designee's Medical Director.

6. APPEALS AND GRIEVANCES OF ADVERSE BENEFIT DETERMINATIONS

a. To file an Appeal or Grievance of an Adverse Benefit Determination, a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member may contact the Plan at the address and telephone number located on the Member's ID Card or submit a written request and any supporting record or medical documentation within 180 days of receipt of the written Notification of the Adverse Benefit Determination to the following:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114
410-581-3000

The Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance or Appeal. *See* paragraph 10 below for additional information.

b. 1) A Member has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;

2) A Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim for Benefits;

3) The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

c. In addition to the requirements of paragraphs 6.b.1) through 3) herein, the following apply:

1) The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an individual who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal or Grievance nor the subordinate of such individual;

2) In deciding a Grievance of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/Investigational or not Medically Necessary or appropriate, the Plan or the Plan's Designee shall consult with a Health Care Provider with the same specialty as the treatment under review;

3) Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Member's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

4) Health Care Providers, engaged for purposes of a consultation under paragraph 6.c.2) herein, shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor subordinates of any such individuals; and

5) In the case of a Claim Involving Urgent Care, a request for an expedited Appeal or Grievance of an Adverse Benefit Determination may be submitted orally or in writing by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member; and the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its determination in writing within 24 hours of receipt of the expedited request for Appeal or Grievance.

d. Full and Fair Review. The Plan or the Plan's Designee shall allow a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to review the claim file and to present evidence and written testimony as part of the internal claims, Appeals and Grievances processes. Specifically, in addition to the requirements of paragraphs 6.b.1) through 3) herein, the following apply:

1) The Plan or the Plan's Designee shall provide the Member, the Member's Representative or Health Care Provider acting on behalf of the Member, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Grievance Decision or Appeal Decision is required to be provided under paragraphs 7 and 8 herein, to give the Member a reasonable opportunity to respond prior to that date; and

2) Before the Plan or the Plan's Designee issues a Grievance Decision or an Appeal Decision based on a new or additional rationale, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Grievance Decision or Appeal Decision is required to be provided under paragraphs 7 and 8 herein, to give the Member, the Member's Representative or Health Care Provider acting on behalf of the Member a reasonable opportunity to respond prior to that date.

7. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (GRIEVANCE DECISIONS)

a. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its benefit determination on review of an Adverse Decision in accordance with the following, as appropriate.

1) Urgent Care Claims. In the case of a Claim Involving Urgent Care, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph 9 herein, of the Grievance Decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the Member's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 24 hours of the orally communicated Grievance Decision.

2) Pre-Service Claims. In the case of a Pre-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph 9 herein, of the Grievance Decision within a reasonable period of time appropriate to the medical circumstances. Oral Notification shall be provided not later than thirty (30) days after the filing date of the Member, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within five (5) working days of the Grievance Decision.

3) Post-Service Claims. In the case of a Post-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph 9 herein, of the Grievance Decision within a reasonable period of time. Oral Notification shall be provided not later than forty five (45) working days after the filing date of the Member's, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within five (5) working days of the Grievance Decision.

b. If the Plan or the Plan's Designee does not have sufficient information to complete its Grievance Decision, the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within five (5) working days after the Filing Date of the Grievance by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan or the Plan's Designee. The Plan or the Plan's Designee Notification shall:

1) Notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member that it cannot proceed with reviewing the Grievance unless additional information is provided; and

2) Assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in gathering the necessary information without further delay.

c. The Plan or the Plan's Designee may extend the thirty (30) day or forty five (45) -working day period required for making an Grievance Decision under paragraph 7.a.2), 3) with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of no longer than thirty (30) working days.

The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.

d. Calculating Time Periods. For purposes of paragraph 7 herein, the period of time within which the review of a Grievance Decision shall be made begins at the time a Grievance is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph 7.b herein due to a Member's, the Member's Representative's or Health Care Provider's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member until the date on which the Member, the Member's Representative or Health Care Provider acting on behalf of the Member responds to the request for additional information.

e. In the case of Grievance, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs 6.b, 6.c, and 6.d herein as is appropriate.

8. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS)

a. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its Appeal Decision no later than sixty (60) working days after the filing date of the Member, the Member's Representative 's or Health Care Provider's Appeal. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within thirty (30) calendar days of the Appeal Decision.

b. The Plan or the Plan's Designee may extend the sixty (60) working day period required for making an Appeal Decision under paragraph 8.a above with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of no longer than thirty (30) working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.

c. Calculating Time Periods. For purposes of paragraph 8 herein, the sixty (60) -working day period within which a benefit determination on review shall be made, subject to any extension granted pursuant to paragraph 8.b above, begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make an Appeal Decision accompanies the filing.

9. MANNER AND CONTENT OF NOTIFICATION OF GRIEVANCE DECISION OR APPEAL DECISION

The Plan or the Plan's Designee shall provide a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with written or electronic Notification after it has provided oral communication of the Grievance Decision or Appeal Decision. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member:

a. The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount, if applicable).

b. The specific factual basis for the adverse determination;

c. Reference to the specific criteria and standards, including interpretive guidelines, on which the benefit determination is based;

d. A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim For Benefits;

e. A statement describing any voluntary Appeal or Grievance procedures offered by the Plan and the Member's right to obtain the information about such procedures; and

f. 1) If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination, either (a) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (b) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or

2) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

g. In the case of a Grievance involving an Adverse Decision, a statement that includes the following information:

1) The name, business address, and business telephone number of the Plan Designee's Medical Director who made the decision;

2) That the Member, the Member's Representative, or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within four (4) months after receipt of the Grievance Decision;

3) The Commissioner's address, telephone number, and facsimile number;

4) A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative, or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

5) The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mailing address; and

6) A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

h. In the case of an Appeal involving a Coverage Decision, a statement that includes the following information:

1) That the Member, the Member's Representative, or Health Care Provider acting on behalf of the Member has the right to file a Complaint with the Commissioner within four (4) months after receipt of the Appeal Decision;

2) The Commissioner's address, telephone number, and facsimile number;

3) A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

4) The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mailing address; and

5) A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

i. Grievance Decisions and Appeal Decisions are made under the direction of the Plan Designee's Chief Medical Officer:

1501 S. Clinton Street
Baltimore, Maryland 21224
410-581-3000

10. FILING OF COMPLAINT AFTER RECEIPT OF NOTIFICATION OF GRIEVANCE DECISIONS OR APPEAL DECISIONS

a. Within four (4) months after the date of receipt of an Appeal Decision or a Grievance Decision, a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner for review of the Grievance Decision or Appeal Decision.

b. A Member, the Member's Representative, or Health Care Provider acting on behalf of the Member may file a Complaint without first exhausting the Plan's internal Grievance or Appeals process if:

1) In the case of an Adverse Decision:

(a) The Plan or the Plan's Designee waives the requirement that the internal Grievance process be exhausted before filing a Complaint with the Commissioner;

(b) The Plan or the Plan's Designee failed to comply with any of the requirements of the internal Grievance process;

(c) The Member, the Member's Representative or Health Care Provider acting on behalf of the Member provides sufficient information and supporting documentation in the Complaint to demonstrate a Compelling Reason.

2) In the case of a Coverage Decision, the Complaint involves an Urgent Medical Condition for which care has not been rendered.

c. The remaining provisions of this paragraph 10 apply to Complaints regarding Adverse Decisions and Grievance Decisions.

1) The Commissioner shall notify the Plan or the Plan's Designee of the Complaint within five (5) working days after the date the Complaint is filed with the Commissioner;

2) Except for an Emergency Case (Claim Involving Urgent Care), the Plan or the Plan's Designee shall provide to the Commissioner any information requested by the Commissioner no later than seven (7) working days from the date the Plan or the Plan's Designee receives the request for information;

d. 1) Except as provided in paragraph 10.d.2) below, the Commissioner shall make a final decision on a Complaint:

(a) Within forty five (45) days after a Complaint is filed regarding a Pre-Service Claim;

(b) Within forty five (45) days after a Complaint is filed regarding a Post-Service Claim; and

(c) Within 24 hours after a Complaint is filed regarding a Claim Involving Urgent Care.

2) The Commissioner may extend the period within which a final decision is to be made under paragraph.10.d.1) for up to an additional thirty (30) working days if:

(a) The Commissioner has not yet received information requested by the Commissioner; and

(b) The information requested is necessary for the Commissioner to render a final decision on the Complaint.

e. The Commissioner shall seek advice from an independent review organization or medical expert for Complaints filed with the Commissioner that involve a question of whether a Pre-Service Claim or a Post-Service Claim is Medically Necessary. The Commissioner shall select an independent review organization or medical expert to advise on the Complaint in the manner set forth in § 15-10A-05 of the Insurance Article, Annotated Code of Maryland.

f. The Plan or the Plan's Designee shall have the burden of persuasion that it's Adverse Decision or Grievance, as applicable, is correct during the review of a Complaint by the Commissioner or Designee of the Commissioner, and in any hearing held regarding the Complaint.

g. As part of the review of a Complaint, the Commissioner or Designee of the Commissioner may consider all of the facts of the case and any other evidence deemed Relevant.

h. Except as provided below, in responding to a Complaint, the Plan or the Plan's Designee may not rely on any basis not stated in its Adverse Benefit Determination.

1) The Commissioner may allow the Plan or the Plan's Designee, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to provide additional information as may be Relevant for the Commissioner to make a final decision on the Complaint.

2) The Commissioner shall allow the Member, the Member's Representative or Health Care Provider acting on behalf of the Member at least five (5) working days to provide the additional information.

3) The Commissioner's use of additional information may not delay the Commissioner's decision on the Complaint by more than five (5) working days.

i. The Commissioner may request the Member or a legally authorized designee of the Member to sign a consent form authorizing the release of the Member's medical records to the Commissioner or Designee of the Commissioner that are needed in order for the Commissioner to make a final decision on the Complaint.

j. Subject to paragraph 7, a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner if the Member, the Member's Representative or Health Care Provider acting on behalf of the Member does not receive the Plan's Grievance Decision within the following timeframes:

1) Within thirty (30) days after the filing date of a Grievance regarding a Pre-Service Claim;

2) Within forty five (45) working days after the filing date of a Grievance regarding a Post-Service Claim; and

3) Within 24 hours after the receipt of a Grievance regarding a Claim Involving Urgent Care.

NOTE: The Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance. Contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
410- 528-1840 or 1-877- 261-8807
Fax: 410- 576-6571
E-mail: heau@oag.state.md.us

11. MEMBER COMMENTS AND QUALITY COMPLAINTS

The Plan provides Members an opportunity to present comments or any other questions or concerns with regard to operations or administration of the Plan, and to file a complaint regarding any Plan service. All comments and complaints should be addressed to the Plan Administrator. In the event of dissatisfaction with a determination made by the Member Services Department, the procedures listed below must be followed.

Inquiries, comments, and complaints concerning the nature of medical care should also be addressed to the Plan Administrator. The Plan Administrator will assist in filing a quality complaint after all other avenues of resolution have been exhausted.

A Member may complain to the Department of Health and Mental Hygiene, Office of Licensing and Certification Programs, regarding the operation of the Plan. The address and telephone number of the Department is available through our Member Services Department.

The Member may also contact the Maryland Insurance Administration at:

Maryland Insurance Administration
Inquiry and Investigation, Life and Health
200 St. Paul Place
Suite 2700
Baltimore, MD 21202-2272
410-468-2244

12. DEEMED EXHAUSTION OF INTERNAL GRIEVANCE PROCESS (ADVERSE DECISIONS)

If the Plan fails to adhere to the minimum requirements for an internal grievance process relating to an Adverse Decision under § 15-10A-02 of the Insurance Code, Annotated Code of Maryland, the Member is deemed to have exhausted the internal grievance processes of paragraph 6, 7 and 9 herein. Accordingly, the Member may initiate an external review under paragraph 10, as applicable.

O. Coordination of Benefits (COB)

Definitions
MHIP uses the following terms when describing the coordination of benefits process under the Plan:

"Allowable Expenses" means any health care expense, including deductibles, coinsurance and copayments, that is covered in whole or in part by any of the health plans covering the Member. This means that any expense or portion of an expense that is not covered by any of the health plans is not an Allowable Expense. If the Plan is advised by a Member that all health plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary health plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible as stated in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

For example, the following expenses or Health Care Services are not considered an Allowable Expense:

- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the health plans routinely provides coverage for private Hospital rooms) is not an Allowable Expense.

- If a Member is covered by two (2) or more health plans, then the amount in excess of this Plan's Allowed Benefit for a specific benefit is not an Allowable Expense.

"Health plan" means any of the following that provides benefits or services for medical care, dental care, or health treatment:

- Group insurance contracts and group subscriber contracts;
- Self-insured arrangements of group or group-type coverage;
- Individual insurance contracts;
- Individual or group nonprofit health service plan contracts;
- Individual or group health maintenance organization contracts;
- The medical components of long-term care insurance, such as skilled nursing care; and
- Coverage under a government health plan, including Medicare (but excluding Medicaid).

"Health plan" does not include:

- Hospital indemnity benefit of $200 per day or less;
- An individually underwritten and issued guaranteed renewable, specified disease policy that does not provide benefits on an expense incurred basis;
- An individually underwritten and issued guaranteed renewable, intensive care policy that does not provide benefits on an expense incurred basis;
- School accident-type coverage; and
- Coverage regulated by a motor vehicle reparation law, including personal injury protection (PIP) coverage under a motor vehicle insurance policy.

"Intensive care policy" means a health insurance policy that provides benefits only for treatment received in the specifically designated facility of a Hospital that provides the highest level of care and is restricted to patients who are physically and critically ill or injured.

"Primary health plan" means a health plan whose benefits for a Member's health care coverage must be determined without taking into consideration the existence of any other health plan. A health plan is a primary health plan if:

- The health plan either has no order of benefit determination rules, or its rules differ from those described below; or

- All health plans that cover the individual use the order of benefit determination rules described below, and under those rules the health plan determines its benefits first.

"Secondary health plan" means a health plan is not a primary health plan. If a Member is covered by more than one secondary health plan, the order of benefit determination rules of this Plan decide the order in which secondary health plan benefits are determined in relation to each other. Each secondary health plan shall take into consideration the benefits of the primary health plan(s) and the benefits of any other health plan, which, under the rules set forth below, has its benefits determined before those of that secondary health plan.

"School accident-type coverage" means an insurance policy that covers students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

"Specified disease policy" means a health insurance policy that provides:

- Benefits only for a disease or diseases specified in the policy or for a treatment unique to a specified disease or diseases; or

- Additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

Coordination with Other Coverage
A Member is ineligible to receive or continue to receive MHIP coverage if the Member is eligible for or receiving Medicare, Medicaid or MCHP; has access to or is enrolled in comparable group insurance; or is enrolled in substantially similar individual insurance coverage. *See* Section One, Part E – End of Coverage. This section, *Coordination of Benefits*, should not be interpreted to imply eligibility for MHIP under any circumstances not authorized by the MHIP Board of Directors. *See* COMAR 31.17.03.14 (and related regulations).

Coordination of Benefits (COB) applies to this Plan, if a Member has health care coverage under more than one health plan and the Plan's application of COB rules does not grant or imply eligibility and does not prevent termination from the Plan in accordance with Section One, Part E of this Certificate. If the COB provision applies, the order of benefit determination rules will apply. These rules provide guidance on whether the benefits of this Plan are determined before or after those of another health plan.

The benefits of this Plan shall not be reduced when, under the order of determination rules, this Plan determines its benefits before another health plan. However, the benefits of this Plan may be reduced when, under the order of determination rules, another health plan determines its benefits first. The reduction of benefits is described in the "Effect on the Benefits of This Plan" section that follows.

Order of Determination Rules
When there is a basis for a claim under this Plan and under another health plan, this Plan shall be a secondary plan which has its benefits determined after those of the other health plan, unless:

- The other health plan has rules coordinating benefits with those of this Plan; and
- Both the rules of the other health plan and this Plan require that this Plan's benefits be determined before those of the other health plan.

THIS PLAN DETERMINES ITS ORDER OF BENEFITS USING THE FIRST OF THE FOLLOWING RULES THAT APPLIES:

Non-dependent/dependent – The benefits of the health plan that covers the individual as a primary Subscriber shall be determined before those of the health plan that covers the individual as a dependent.

Dependent child/parents not separated or divorced – Except as stated below, when this Plan and another health plan cover the same child as a dependent of different parents:

- The benefits of the health plan of the parent whose birthday falls earlier in a year are determined before those of the health plan of the parent whose birthday falls later in the year; or
- If both parents have the same birthday, the benefits of the health plan that covered the parent longest shall

determine its benefits first;
- However, if the other health plan does not have the rule described above, but instead has a rule based upon the gender of the parent and, if as a result, the health plans do not agree on the order of benefits, the rule in the other health plan will determine the order of benefits.

Dependent child/parents separated or divorced –

- If the court decree states that one of the parents is responsible for the health care expenses or health insurance coverage of the child and the health plan of that parent has actual knowledge of those terms, that plan is the primary health plan. If the parent with responsibility does not have health insurance coverage for the dependent child, but that parent's spouse does, the spouse's health plan is the primary health plan. This shall not apply with respect to any claim determination period or Plan Year during which benefits are paid or provided before the health plan has actual knowledge of the terms of the court decree.
- If the court decree states that both parents are responsible for the dependent child's health care expenses or health insurance coverage, the order of determination for dependent child/parents not separated or divorced", as stated above, shall apply.
- If a court decree states that the parents have joint custody, without specifying that one parent has responsibility for the health care expenses or health insurance coverage of the dependent child and the dependent child's residency is split between the parents, the order of benefit determination shall be determined in accordance with the order of determination for dependent child/parents not separated or divorced as stated above.
- If there is no court decree allocating responsibility for the child's health care expenses or health insurance coverage, and two or more health plans cover an individual as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - ► First, the health plan that covers the custodial parent;
  - ► Second, the health plan of the spouse of the custodial parent;
  - ► Third, the health plan of the non-custodial parent; and
  - ► Fourth, the health plan of the spouse of the non-custodial parent.

If both parents share custodial care, the order of determination for dependent child/parents not separated or divorced as stated above shall apply.

Active or Inactive Employee –

- The benefits of a health plan that covers an employee who is neither laid off nor retired are determined before those of a health plan that covers that individual as a laid off or retired employee.
- If the other health plan does not have this rule, and if, as a result, the health plans do not agree on the order of benefits, this rule is ignored.
- Coverage provided to an individual as a retired employee and coverage provided as a dependent of an active employee shall be determined under order of determination rule above.

Longer/Shorter Length of Coverage –

- If none of the above rules determines the order of benefits, the health plan that covered the Member for the longer period of time is the primary health plan.
- To determine the length of time an individual has been covered under a health plan, two plans shall be treated as one if the individual was eligible under the second health plan within 24 hours after the first health plan ended.
- The start of the new health plan does not include:
  - ► A change in the amount or scope of a health plan's benefits;
  - ► A change in the entity that pays, provides or administers the health plan's benefits; or
  - ► A change from one type of health plan to another, such as from a single employer plan to that of a multiple employer plan.
- The individual's length of time covered under a plan is measured from the individual's first date of coverage under that health plan. If the date is not readily available for a group plan, the date the individual first became a Member shall be used as the date from which to determine the length of time the individual's coverage under the present health plan has been in force.

If none of the preceding rules determines the order of benefits, the Allowable Expenses shall be shared equally between the health plans.

Effect on the Benefits of this Plan
This section applies when, in accordance with the order of determination rules, this Plan is a secondary health plan as to one or more other health plans. In that event, the benefits of this Plan may be reduced under this section.

The benefits of this Plan shall be reduced when the plan's allowable expense in a claim determination period exceeds the sum of:

- the benefit that would be payable for the Allowable Expense under this Plan, in the absence of this COB provision; and
- the benefit that would be payable for the Allowable Expense under the other health plans, in the absence of provisions with a purpose like that of this COB provision.

In that case, the benefits of this Plan will be reduced so that the benefits under this Plan and the benefits payable under the other health plans do not total more than this Plan's Allowed Benefit. When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

NOTE: The Plan will not reduce, limit, or exclude coverage due to payments to a Member under the Member's Personal Injury Protection Policy (or "PIP"). PIP is insurance coverage, without regard to fault, provided under a Member's motor vehicle insurance policy.

Right to Receive and Release Information

Certain facts about health care coverage and services are needed in order to apply these COB rules and to determine benefits payable under this Plan and other health plans. MHIP or the Plan Administrator may get the facts it needs from or give them to other health plan which MHIP reasonably believes covers the Member during the relevant time period for the purpose of applying these rules and determining benefits payable under this Plan and other health plans covering the Member claiming benefits. MHIP or the Plan Administrator need not tell, or get the consent of, any person. Each Member claiming benefits under this Plan must give MHIP or the Plan Administrator any facts or consents (that may be required by a third party) it needs to apply these rules and determine benefits payable.

Facility of Payment
A payment made under another health plan may include an amount that should have been paid under the Plan. If it does, the Plan Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by the Plan is more than the amount that should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;

2. Insurance companies; or

3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

P. Third Party Liability/Subrogation

The Plan will pay claims, subject to all terms and conditions of the Plan, for medical expenses to treat injury or Illness incurred by a Member as a result of the negligence, or other act, of a third party. If such Member is, or becomes, entitled to recover damages, or any other payment, as a result of the act of a third party, the Plan shall have a right of subrogation. The Plan shall have a first lien against any amount recovered up to the full amount actually paid by the Plan for claims incurred as a result of an act of a third party. The Plan's right to recover pursuant to this provision is not limited by the manner in which all or any portion of a sum recovered from a third party is characterized. The Plan has the right to assert such lien at any time. The Plan also has the right to institute a claim or lawsuit in the Member's name to pursue recovery. Members agree to cooperate fully with Plan efforts to pursue its rights as set forth in this paragraph. Such cooperation may include executing a written instrument. Members shall take no action prejudicing the rights and interests of the Plan under this provision. Costs incurred pursuing recovery, including attorney fees, are excluded from any amount subject to this right of subrogation.

NOTE: This provision does not apply to any benefits received by a Member under a Personal Injury Protection Policy (or "PIP"). PIP is insurance coverage, without regard to fault, provided under a Member's motor vehicle insurance policy.

Section Three - Covered Services

This section explains the Deductibles, Out-of-Pocket Maximums, Prescription Drug Annual Maximum, and Lifetime Maximums applicable under the Plan's Benefit Options. This section also includes a Schedule of Benefits that outlines the Covered Services and the payments for those services under each Benefit Option. It also includes information about the Plan's Prescription Drug program as well as detailed information about the Mental Health and Substance Abuse benefits available under the Plan.

NOTE: Carefully read this entire Certificate to identify the Health Care Services that are Covered Services and to determine what, if any, limitations or requirements exist for those Covered Services under the Benefit Option selected. Section Four of this Certificate contains important information about services and other items that are excluded from coverage. The Member is responsible for paying the designated Copayment or Deductible and/or Coinsurance as shown on the Schedule of Benefits in this section.

A. Plan Year Deductibles, Out-of-Pocket Maximums, Prescription Drug Annual Maximum and Lifetime Maximum

Plan Year Deductibles

Except where expressly stated in this Certificate, a Deductible for medical and/or Prescription Drug services must be met each Plan Year, which begins on July 1st and ends on June 30th, before the Plan pays for Covered Services.* With the exception of the HDP Benefit Option, any medical and Prescription Drug Deductibles are separate. Each Deductible is a designated annual fixed-dollar amount that must be paid for medical and/or Prescription Drug Covered Services before the Plan begins to pay. For new Members who joined the Plan during the Plan Year, the applicable Deductible may be satisfied during the remainder of the Plan Year. Existing Members have the full Plan Year during which to satisfy the applicable Deductible. Under certain circumstances, both new and existing Members may be eligible for a Deductible Carryover in the following Plan Year for a portion of their prior year Deductible expenses. (*See* Deductible Carryover discussion below). Once the medical or Prescription Drug Deductible is met, any applicable Copayment or Coinsurance for medical or Prescription Drug Covered Services must be paid and no additional Deductible payments will be required for the remainder of the Plan Year.

$200 Deductible PPO, $500 Deductible PPO and $1,000 Deductible PPO Benefit Options

- Once the medical services Deductible has been met, the applicable Copayment or Coinsurance will apply.
- Copayments for Emergency Services contribute to satisfying the Deductible.
- Once any Prescription Drug Deductible has been satisfied, applicable Copayments will apply.

NOTE: MHIP+ Members have no Deductible for Prescription Drug services.

$2,600 High Deductible Plan (HDP) Benefit Option

- The Deductible in the HDP Benefit Option is satisfied through a combination of payments for both medical and Prescription Drug Covered Services (the "Combined Deductible"). Once this Individual or Family Combined Deductible is met, any applicable Coinsurance or Copayments will apply.
- Copayments for Emergency Services contribute to satisfying the Combined Deductible.

*The Plan determines if the Deductible has been satisfied based on when allowable claims are received and processed. There may be a delay between the times claim costs are incurred and when the Plan determines that the Deductible has been satisfied. Any temporary overpayment resulting from the accumulation of allowable Deductible expenses will be refunded.

Deductibles

The chart below outlines the applicable medical and Prescription Drug Deductibles for each Benefit Option.

Benefit Option	Medical Deductible	Prescription Drug Deductible
$200 Deductible PPO (MHIP+ Only)	$200 per Member with a $400 family maximum	None
$500 Deductible PPO (MHIP+ Only)	$500 per Member with a $1,000 family maximum	None
$500 Deductible PPO	$500 per Member with a $1,000 family maximum	$100 per Member*
$1,000 Deductible PPO	$1,000 per Member with a $2,000 family maximum	$250 per Member with a $500 family maximum
$2,600 HDP	Combined Medical and Prescription Drug Deductible ("Combined Deductible") of $2,600 per Member or $5,200 per family	

NOTE: The Prescription Drug Deductible does not apply to the MHIP+ Benefit Options.

Under the PPO Benefit Options, the medical and Prescription Drug Deductibles are separate. Eligible expenses incurred for medical services do not count towards the Prescription Drug Deductible and eligible expenses incurred for Prescription Drug services do not count towards the medical Deductible.

NOTE: Under the HDP Benefit Option, the medical and Prescription Drug Deductible is a combined amount and all eligible costs incurred for Covered Services, whether medical or Prescription Drug, count towards the single Combined Deductible.

Each Member can satisfy his/her own Deductible by meeting the individual Member Deductible. In addition, eligible expenses for all covered Members can be combined to satisfy the family Deductible. An individual family Member may not contribute more than the individual Member Deductible toward meeting the family Deductible. Once the family Deductible has been met, this will satisfy the Deductible for all covered family Members, even if a family Member has not met his or her per Member Deductible.

***EXCEPTION:** Under the $500 Deductible PPO Benefit Option (non-MHIP+), there is a $100 per Member Deductible for Prescription Drug services with no family maximum. Each family Member must separately meet this per Member $100 Prescription Drug Deductible and this Prescription Drug Deductible cannot be reduced by eligible expenses for Prescription Drugs incurred by any other family Member.

The following costs and payments do not count against any Deductible or Combined Deductible:

- The portion of any Provider charge for a Covered Service in excess of the Allowed Benefit;
- Expenses incurred for Covered Services due to a failure to comply with the Prior Authorization requirements (*See* Section Two, Part H - Covered Services Requiring Prior Authorization);
- Costs incurred for non-Covered Services listed in Section Four, Exclusions: Services Not Covered by the Plan in this Certificate; and
- The difference in price between the Brand Name Drug and its generic equivalent when the Member requests a Brand Name Drug that has a generic equivalent.

Deductible Carryover (For PPO Benefit Options ONLY)

A "Deductible Carryover" is a credit for charges that can be applied to a Plan Year Deductible under a PPO Benefit Option. Any expenses incurred during the fourth (4^{th}) quarter of the Plan Year (April 1 – June 30) that apply to a current medical or Prescription Drug Deductible, will also be applied toward a medical or Prescription Drug Deductible for the next Plan Year, beginning on July 1st. **NOTE:** ***Members who select the HDP Benefit Option are not eligible for any Deductible Carryover.***

For example, if a Member is enrolled in the $1,000 PPO Benefit Option and the Member pays $500 of the $1,000 medical Deductible during the month of April, May or June, a credit of $500 will be applied to the $1,000 medical services Deductible that begins on July 1st.

Likewise, if a Member has paid $100 toward a Prescription Drug Deductible, under the $1,000 PPO Benefit Option, in those months, a credit of $100 that will be applied to the $250 Prescription Drug services Deductible that begins on July 1st.

Deductible Carryover following Death of Subscriber
If a Subscriber enrolled in a PPO or HDP benefit option dies and the coverage of a surviving Dependent or Dependents is converted to a new contract, any expenses incurred toward the Deductible under the contract of the deceased Subscriber will be applied to the new contract of the surviving Dependent or Dependents.

Coinsurance Payments

In general, after a Plan Year Deductible has been met, the PPO and HDP Benefit Options require payment of 20% Coinsurance of the Allowed Benefit for most Covered Services rendered by an in-network Provider, and 40% of the Allowed Benefit for most Covered Services rendered by an out-of-network Provider.

Payments made for non-Covered Services or payments made in excess of the Allowed Benefit are not applied to Coinsurance amounts.

Out-of-Pocket Maximums

The out-of-pocket maximum is the maximum amount to be paid for a share of benefits in any Plan Year for either medical services or Prescription Drugs. Prescription Drug benefits will still be subject to the Prescription Drug Annual Maximum. The Plan has a medical benefit out-of-pocket maximum and a Prescription Drug out-of-pocket maximum as follows:

PPO BENEFIT OPTIONS

For the PPO Benefit Options, there is a separate medical benefit out-of-pocket maximum and a Prescription Drug out-of-pocket maximum.

Medical Benefit Out-of-Pocket Maximums
The annual medical benefit out-of-pocket maximum is the most that can be paid for a share of medical benefits during a single Plan Year. When this out-of-pocket maximum has been reached, no further Deductible, Coinsurance, or Copays will be required during the Plan Year for medical benefits, except for Emergency Services Copays. Thereafter, the Plan will pay 100% of Covered Services for medical benefits according to the Plan's Allowed Benefits for services provided by both in-network and out-of-network Providers for the remainder of that Plan Year.

The chart below outlines the applicable annual medical benefit out-of-pocket maximums for each PPO Benefit Option:

Benefit Option	Individual Medical Benefit Out-of-Pocket Maximum	Family Medical Benefit Out-of-Pocket Maximum
$200 Deductible PPO (MHIP+ Only)	$1,000	$2,000
$500 Deductible PPO	$3,000	$6,000
$1,000 Deductible PPO	$3,500	$7,000
$2,600 HDP	Combined Medical Benefit and Prescription Drug Out-of-Pocket Maximum of $4,600 per Member or $9,200 per family	

For the PPO Benefit Options, the following amounts do <u>not</u> count against the annual medical benefit out-of-pocket maximum:

- Prescription Drug Deductibles, Coinsurance and Copays;
- Amounts paid for Prescription Drugs administered or dispensed by a Health Care Facility for a Member who is a patient in the health care facility. This does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the Health Care Facility;
- The portion of any Provider charges for a Covered Service that is in excess of the Allowed Benefit;
- Expenses incurred for Covered Services due to failure to comply with the Prior Authorization requirements (*See* Section Two, Part H - Covered Services Requiring Prior Authorization); and
- Amounts incurred for non-Covered Services listed in Section Four, Exclusions: Services Not Covered by the Plan in this Certificate.

Each Member can satisfy his/her own annual individual medical benefit out-of-pocket maximum by meeting the individual medical benefit out-of-pocket maximum. In addition, eligible expenses of all covered family Members can be combined to satisfy the family medical benefit out-of-pocket maximum. An individual family Member cannot contribute more than the individual medical benefit out-of-pocket maximum toward meeting the family medical benefit out-of-pocket maximum. Once the family medical benefit out-of-pocket maximum has been met, this will satisfy the medical benefit out-of-pocket maximum for all family Members even if a family Member has not fully met his or her individual medical benefit out-of-pocket maximum. Once the medical benefit out-of-pocket maximum has been satisfied, benefits will be paid in full.

Prescription Drug Out-Of-Pocket Maximum

The PPO Benefit Options have a per Member Prescription Drug out-of-pocket maximum. The Prescription Drug out-of-pocket maximum is the most a Member will pay in Copayments or Coinsurance during a single Plan Year for Prescription Drug benefits under the Plan's Prescription Drug program up the Prescription Drug Annual Maximum. The Plan imposes a Prescription Drug Annual Maximum on each Member. *See* Section Three, Part C – Prescription Drug program. When the Member has reached this out-of-pocket maximum, no further Deductible, Copayments or Coinsurance will be required for Prescription Drug benefits provided by the Plan up to the Prescription Drug Annual Maximum

The chart below outlines the applicable annual Prescription Drug out-of-pocket maximums for each PPO Benefit Option:

Benefit Option	Individual Prescription Drug Out-of-Pocket Maximum
$200 Deductible PPO (MHIP+ Only)	$1,500
$500 Deductible PPO	$2,000
$1,000 Deductible PPO	$2,000

The following amounts do not count towards the annual Prescription Drug out-of-pocket maximum for the PPO Benefit Options:

- Deductibles, Coinsurance and Copays paid for Covered Services other than covered Prescription Drugs dispensed under the Plan's Prescription Drug program;
- Deductibles, Coinsurance and Copays paid for Prescription Drugs that are administered or dispensed by a Health Care Facility for a Member who is a patient in the Health Care Facility. This does not apply to Prescription Drugs that are dispensed by a Pharmacy on the Health Care Facility's premises for a Member who is not a patient in the Health Care Facility;
- The portion of any charges for a covered Prescription Drug that is in excess of the Allowed Benefit;
- The difference in price between the Brand Name Drug and the generic equivalent when the Member requests a Brand Name Drug that has a generic equivalent; and
- Amounts incurred for Prescription Drugs not covered under this Certificate.

Each Member can satisfy his/her own annual Prescription Drug out-of-pocket maximum. Each family Member must separately meet the per Member Prescription Drug out-of-pocket maximum and the Member's Prescription Drug out-of-pocket maximum cannot be reduced by eligible expenses for Prescription Drugs incurred by any other family Member. Once the Prescription Drug out-of-pocket maximum has been met, Prescription Drug benefits will be paid in full up to $100,000 for each Member.

HDP Benefit Option

For the HDP Benefit Option, there is a single combined annual out-of-pocket maximum that combines payments for medical benefits and Prescription Drugs and there is no separate Prescription Drug out-of-pocket maximum. However, the Plan does impose a $100,000 annual Prescription Drug maximum on each Member.

Individual and Family Combined Out-of-Pocket Maximums
The chart below outlines the combined annual out-of-pocket maximum for the HDP Benefit Option, excluding the $100,000 annual Prescription Drug maximum for each Member:

Benefit Option	Individual Medical Benefit Out-of-Pocket Maximum	Family Medical Benefit Out-of-Pocket Maximum
$2,600 HDP	Combined Medical Benefit and Prescription Drug Out-of-Pocket Maximum of $4,600 per Member or $9,200 per family	

For the HDP Benefit Option, the entire Combined Deductible will count towards the combined out-of-pocket maximum. The following amounts do not count toward the combined out-of-pocket maximum under the HDP Benefit Option:

- The portion of any Provider charges for a Covered Service that is in excess of the Allowed Benefit;
- Expenses incurred for Covered Services due to failure to comply with the Prior Authorization requirements (*See* Section Two, Part H - Covered Services Requiring Prior Authorization);
- Amounts incurred for non-Covered Services listed in Section Four, Exclusions: Services Not Covered by the Plan in this Certificate;
- The portion of any charges for a covered Prescription Drug that is in excess of the Allowed Benefit;
- The difference in price between the Brand Name Drug and the generic equivalent when the Member requests a Brand Name Drug that has a generic equivalent; and
- Amounts incurred for Prescription Drugs not covered under this Certificate.

Each Member can satisfy his/her own individual combined annual out-of-pocket maximum by meeting the individual combined out-of-pocket maximum. In addition, eligible expenses of all covered family Members can be combined to satisfy the family combined annual out-of-pocket maximum. An individual family Member cannot contribute more than the individual combined out-of-pocket maximum toward meeting the family combined out-of-pocket maximum. Once the family combined out-of-pocket maximum has been met, this will satisfy the combined out-of-pocket maximum for all family Members even if a family Member has not fully met his or her individual combined out-of-pocket maximum. Once the combined out-of-pocket maximum has been satisfied, benefits will be paid in full.

Prescription Drug Annual Maximum for Each Member

The Prescription Drug Annual Maximum is the maximum dollar amount of Prescription Drug Covered Services payable by the Plan towards each Member's claims during a Plan Year.

Prescription Drug Annual Maximum (per Member)	$100,000

Lifetime Maximum for Each Member

The Lifetime Maximum is the maximum dollar amount of combined medical and Prescription Drug Covered Services payable by the Plan towards each Member's claims during the Member's lifetime.

Lifetime Maximum (per Member)	$2,000,000

B. Schedule of Benefits

The charts below show the level of Copayment or Coinsurance to be paid by the Member for each Covered Service. Unless otherwise stated below, these Copayment and Coinsurance amounts are in addition to any Deductible.

Allergy Services

Allergy Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Provider Office Visits	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Allergy Testing	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Allergy Injections	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Ambulance Transport (Non-Emergency)

Ambulance Transport (Non-Emergency)	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Ground and Air Ambulance Transport	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Blood & Blood Products

All cost recovery expenses for Blood, Blood Products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin are covered.

Blood and Blood Products	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Blood and Blood Products	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Chemotherapy/Radiation Therapy

Chemotherapy/ Radiation Therapy	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Provider Office Visits	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Chemotherapy/ Radiation Therapy	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Inpatient Hospital (Prior Authorization required)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Controlled Clinical Trials

Prior Authorization is required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

Controlled Clinical Trials	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Provider Office Visits	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Hospital	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Surgery Facility Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Cosmetic and Reconstructive Surgery

Prior Authorization may be required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

- Cosmetic and related reconstructive surgery is limited to the restoration of bodily function or correction of deformity resulting from disease, trauma, or congenital deformity including cleft lip or cleft palate or both.

- Surgical services are covered for a Medically Necessary mastectomy; reconstruction of the breast on which the mastectomy has been performed; and surgery and reconstruction of the other breast to produce a symmetrical effect regardless of the Member's insurance status at time of the mastectomy or the time lag between the mastectomy and reconstruction.

- Prostheses and services related to physical complication for all stages of mastectomy, including lymphedema are covered.

Covered Cosmetic and Reconstructive Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Provider Office Visits	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Hospital (Prior Authorization required)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Surgery Facility Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Dental Trauma

Prior Authorization may be required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

Covered Services include:

Dental trauma services performed in conjunction with treatment to teeth, gums, or a fractured jaw, but only when:

- The services are necessitated as a direct result of an Accidental Injury that occurred within the last six (6) months;
- The Accidental Injury is not caused by biting or chewing; and
- In reference to injury to a tooth, benefit coverage is limited to the repair of sound and natural teeth to pre-injury level.

Operations on or for treatment of or to the teeth or supporting tissues of the teeth, but only when the services are for the removal of tumors or cysts.

General anesthesia and associated Hospital or ambulatory facility charges in conjunction with dental care provided to the following:

- Children who are age seven (7) or younger or developmentally disabled and for whom a:
  - ► Successful result cannot be expected from dental care provided under local anesthesia, because of a physical, intellectual, or other medically compromising condition of the Member; and
  - ► Superior result can be expected from dental care provided under general anesthesia.

- Children who are age seventeen (17) or younger who:

  - ► Are extremely uncooperative, fearful, or uncommunicative;
  - ► Have dental needs of such magnitude that treatment should not be delayed or deferred; and
  - ► Are Members for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

Dental Trauma Service for Injury to Sound and Natural Teeth or for the Removal of Tumors or Cysts, including general anesthesia for certain children	**PPO In-Network**	**PPO Out-of-Network**	**HDP In-Network**	**HDP Out-of-Network**
Provider Office Visits	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Hospital (Prior Authorization required)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Surgery Facility Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Diabetic Equipment and Services

Coverage will be provided for Medically Necessary diabetes treatment, equipment, supplies; and Outpatient self-management training and educational services (including, medical nutritional counseling at a CareFirst approved facility).

- Diabetes treatment, equipment and supplies;
- Podiatric (foot) appliances for prevention of complications associated with diabetes (in accordance with Medicare guidelines); and
- Diabetes education services.

Diabetic Equipment and Services	**PPO In-Network**	**PPO Out-of-Network**	**HDP In-Network**	**HDP Out-of-Network**
Provider Office Visits	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Eye Care *Dilated eye exam (1 per Plan Year for diabetic Members)*	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Patient Education	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Podiatrist	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Prescription Drugs and Insulin	See the Prescription Drug Benefit	See the Prescription Drug Benefit	See the Prescription Drug Benefit	See the Prescription Drug Benefit
Diabetic Equipment	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Dialysis: Hospital-based, Outpatient Dialysis Center, or Home Dialysis

Covered Services include Medically Necessary dialysis treatment, hemodialysis, or peritoneal dialysis for chronic kidney conditions at an Outpatient dialysis center and training in the operation of dialysis equipment, including supplies for and maintenance of dialysis equipment, used in a Member's home. Hospital-based dialysis services provided on an Inpatient basis requires Prior Authorization from the Plan. *See* "Hospital Inpatient Services" in this Section.

	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Outpatient Dialysis Services or Home Dialysis	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Durable Medical Equipment and Disposable Medical Supplies (DME/DMS)

To be covered, Durable Medical Equipment and Disposable Medical Supplies must be Medically Necessary.

DME/DMS include, but are not limited to, the following:

- Nebulizers, peak flow meters, crutches, walkers, oxygen, and equipment for the administration of oxygen, standard manual wheelchairs, and manual hospital beds;
- Medically Necessary medical foods and low protein modified food products for the therapeutic treatment, under the direction of a physician, of metabolic diseases and inborn deficiencies of amino acid metabolism. A low protein modified food product means a food product that is specially formulated to have less than 1 gram of protein per serving (excluding a natural food that is naturally low in protein);
- Ostomy and catheter supplies;
- Medically Necessary supplies required to operate DME;
- Sterile surgical supplies required immediately after surgery;
- Medically Necessary supplies needed to operate or use covered DME or Prosthetics or Orthotics; and
- Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services; and
- Insulin pumps and associated supplies.

DME/DMS does not include convenience items, including, but not limited to, the following:

- Air Conditioners
- Air Cleaners
- Humidifiers
- Water Purifiers
- Physical Fitness Equipment
- Bathtub Lifts
- Bathtub Seats
- Carafes
- Elevators
- Emesis Basins
- Over Bed Tables
- Raised Toilet Seats
- Standing Tables

For mastectomy-related supplies, see the **Cosmetic and Reconstructive Surgery** benefit.

Rental DME items may not become the property of the Member and must be returned to the DME Provider when no longer needed or upon termination of the Member's coverage, whichever occurs first. If the equipment is not returned by the Member or is returned in poor condition, the Member may be responsible for the replacement or repair cost.

Diabetic supplies (*e.g.*, insulin syringes, test strips) are covered under the Prescription Drug program.

Durable and Non-Durable Supplies	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Durable Medical Equipment	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Disposable Medical Supplies	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Emergency Services and Urgent Care

Member Services must be contacted by calling (866) 780-7105 within 48 hours of seeking Emergency Services that result in an Inpatient Hospital admission.

Urgent Care Services are provided at an Urgent Care center or facility for the relief of acute pain, initial treatment of acute infection, or a medical condition that requires medical attention, and a brief time lapse before care is obtained does not endanger life or permanent health.

Urgent Care conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion, and breathing difficulties (other than those of sudden onset and persistent severity).

***See* Section Two, Part I - Emergency Services and Part J - Urgent Care.**

Emergency Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Care for a Medical Emergency Provided in a Hospital Emergency room (ER) (no admission to Hospital)	20% of the Allowed Benefit plus $75 Copay	20% of the Allowed Benefit plus $75 Copay	20% of the Allowed Benefit plus $75 Copay	40% of the Allowed Benefit plus $75 Copay
Care for a Medical Emergency Provided in a Hospital Emergency room (ER) (admission to Hospital)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Urgent Care	**PPO In-Network**	**PPO Out-of-Network**	**HDP In-Network**	**HDP Out-of-Network**
Urgent Care Center/Facility	20% of the Allowed Benefit plus $35 Copay	40% of the Allowed Benefit plus $35 Copay	20% of the Allowed Benefit plus $35 Copay	40% of the Allowed Benefit plus $35 Copay

Family Planning Services

The following Medically Necessary services are covered:

- Counseling;
- Insertion or removal of contraceptive devices and examination associated with the use of contraceptive drugs or devices;
- Voluntary sterilization; and
- Coverage for oral contraceptives. (*See* the Prescription Drugs section of this Schedule of Benefits)

Family Planning Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Provider Office Visit	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Sterilization ▪ Inpatient (Prior Authorization required) ▪ Outpatient Surgery Facility Services ▪ Provider Office	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Habilitative Care

Habilitative Care is covered for children between 0 and 19 years of age with a congenital or genetic birth defect and includes services for orthodontics, oral surgery, otologic, audiologic, and speech therapy, physical therapy, and occupational therapy to enhance the Member's ability to function. Congenital or genetic birth defects include, but are not limited to: autism or an autism spectrum disorder, and cerebral palsy. Benefits are not available for Habilitative Services delivered through early intervention and school services.

Habilitative Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Provider Office Visit	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Hospitalization (Prior Authorization required)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Surgery Facility Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Physical, Speech, or Occupational Therapy (30 visits per diagnosis per Plan Year)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Hearing Aids for Minor Children

Benefits for hearing aids are provided for a Member who is a minor child, when the hearing aid is prescribed, fitted and dispensed by a licensed audiologist. The Plan will cover up to the maximum payment as stated below every thirty-six (36) months for one hearing aid for each hearing-impaired ear.

Hearing Aids for Minor Children	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Hearing Aids per Hearing Impaired Ear *(Maximum of $1,400 per ear every 36 months ONLY for Children through 18 years of age)*	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Related Professional Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Home Health Care

Prior Authorization is required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

Benefits for Home Health Care are covered for Members

- As an alternative to otherwise Covered Services in a Hospital or related institution; or
- Who receive less than 48 hours of Inpatient hospitalization following a mastectomy or removal of a testicle or who undergo a mastectomy or removal of a testicle on an Outpatient basis. Benefits provided include:

  ► One (1) home visit scheduled to occur within 24 hours after discharge from the Hospital or Outpatient Health Care Facility; and
  ► An additional home visit, if prescribed by the attending physician.

Home Health Care	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Home Health Care	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Hospice Care

Prior Authorization is required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

Hospice	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Inpatient Hospice Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Hospice Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Hospital Inpatient Services

Prior Authorization is required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

The following Hospital facility services are covered with Prior Authorization:

- Medically Necessary Hospital services; and
- Semiprivate room and board (unless only private rooms are available or a private room is Medically Necessary).

Inpatient Hospital Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Inpatient Hospital Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Infertility Testing and Diagnosis

Prior Authorization is required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

Services provided on an Outpatient basis to determine the **cause** of infertility include, but are not limited to:

- Consultation with a reproductive endocrinology/infertility Specialist;
- Complete semen analysis;
- Midluteal endometrial biopsy;
- Hysterosalpingogram, as an initial test of tubal patency, unless contraindicated;
- A post-coital exam;
- Medically Necessary laboratory testing to determine cause of infertility;
- A diagnostic laparoscopy with chromotubulation; and
- A hysteroscopy if the hysterogram is not normal.

NOTE: The Plan does not cover artificial insemination and infertility treatment, including, but not limited to, in vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, cryogenic or other preservation techniques used in these or similar procedures, or the drugs used in support of any of the above mentioned artificial insemination or infertility treatment.

Infertility Testing and Diagnosis Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Provider Office Visit	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Surgery Facility Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Limited Service Immediate Care

Coverage is provided for treatment of common conditions or ailments requiring rapid and specific treatment that can be administered in a limited duration of time. Limited Service Immediate Care services are non-emergency and non-urgent services. Services are provided in Limited Service Immediate Care Centers, which are mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Examples of common ailments for which a reasonable, prudent layperson possessing an average knowledge of health and medicine would seek Limited Service Immediate Care, include, but are not limited to, ear, bladder, and sinus infections; pink eye; flu; and strep throat.

Limited Service Immediate Care	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Maternity Care

Women are encouraged to contact Member Services at (443) 725-1010 or toll free at (888) 456-2024 as soon as possible once they know they are pregnant. This enables the Plan Administrator to work with the treating Provider to monitor for high-risk pregnancy factors and to assist a parent in completing steps to assure that Plan benefits will be available for the newborn child.

Maternity care is covered as any other medical condition. Coverage includes normal pregnancy and complications of pregnancy. Coverage also includes the following preventive services:

- Screening for asymptomatic bacteriuria;
- Behavioral interventions to promote breastfeeding;
- Screening for Hepatitis B virus infection; and
- Screening for iron deficiency anemia.

Limitations:

- Routine screening sonograms (OB ultrasounds) are covered only if Medically Necessary.
- Audiology screening for newborns limited to one screen and one confirming screen.
- Newborn infants are automatically covered for the first thirty one (31) days (from the date of birth). *See* Section One, Part D - Coverage Changes for details on enrolling a newborn infant.

Maternity Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Provider Office Visits During Pregnancy	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Hospital (No Prior Authorization required for maternity admissions)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Abortions ● Inpatient (Prior Authorization required)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
● Outpatient Surgery Facility Services				

NOTE: The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following an uncomplicated vaginal delivery, or less than 96 hours following an uncomplicated Cesarean section. However, if mother elects a shorter Hospital stay than provided above, the Plan will cover:

- One (1) home visit scheduled to occur within 24 hours after Hospital discharge; and
- An additional home visit if prescribed by the attending Provider.

The Plan will also cover one (1) home visit prescribed by the attending Provider for mother who has a Hospital length of stay more than 48 hours following an uncomplicated vaginal delivery or more than 96 hours following an uncomplicated Cesarean section.

If the mother is required to remain in the Hospital after childbirth (more than 48 hours following an uncomplicated vaginal delivery, or more than 96 hours following an uncomplicated Cesarean section), the Plan will cover up to an additional four (4) days for the newborn.

Mental Health and Substance Abuse Services

Prior Authorization may be required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

Mental Health and Substance Abuse Services for MHIP are administered by the Plan Administrator in cooperation with Magellan Health Services ("Magellan"). Magellan is an independent company.

Members must contact Magellan Health Services at (800) 245-7013 and obtain Prior Authorization prior to receiving Inpatient Mental Health or Substance Abuse services.

Emergency Services: In the event of a crisis, call Magellan's toll-free number, (800) 245-7013, 24 hours a day, 7 days a week. For life threatening emergencies, it is always recommended that Members call 911 to access emergency services.

Mental Health	**PPO In-Network**	**PPO Out-of-Network**	**HDP In-Network**	**HDP Out-of-Network**
Inpatient Psychiatric, Residential Treatment/Crisis Center or Partial Hospital *(Maximum of sixty (60) days per Member per Plan Year, combined with Substance Abuse; two (2) days of Partial Hospitalization equals one (1) Inpatient hospitalization day)* (Prior Authorization required)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Individual Psychiatric Sessions, Intensive Outpatient or Treatment Sessions Group Sessions	30% of the Allowed Benefit	50% of the Allowed Benefit	30% of the Allowed Benefit	50% of the Allowed Benefit
Substance Abuse	**PPO In-Network**	**PPO Out-of-Network**	**HDP In-Network**	**HDP Out-of-Network**
Medication Management	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Substance Abuse Rehabilitation or Partial Hospital *(Maximum of sixty (60) days per Member per Plan Year, combined with Mental Health; two (2) days of Partial Hospitalization equals one (1) Inpatient hospitalization day)* (Prior Authorization required)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Substance Abuse Detoxification/ Withdrawal *(Not Limited)* (Prior Authorization required)	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Individual Substance Abuse Sessions, Intensive Outpatient Treatment Sessions, Group Sessions, or Substance Abuse Intensive Outpatient Rehabilitation (IOP)	30% of the Allowed Benefit	50% of the Allowed Benefit	30% of the Allowed Benefit	50% of the Allowed Benefit
Medication Management	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Oral Surgery

Prior Authorization may be required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

- Benefits for oral surgery include:
  - ► Medically Necessary procedures, as determined by the Plan, to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and are performed lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.
  - ► Medically Necessary procedures, as determined by the Plan, needed as a result of an Accidental Injury, when the Member requests oral surgical services or dental services for sound natural teeth and supporting structures or the need for oral surgical services or dental services for sound natural teeth and supporting structures is identified in the patient's medical records within sixty (60) days of the accident. Benefits for such oral surgical services shall be provided up to three (3) years from the date of injury.
  - ► Medically Necessary oral surgical services for the treatment of cleft lip or cleft palate or both.
- All treatments or procedures for the treatment of Temporomandibular Joint Syndrome (TMJ) and the treatment for craniomandibular pain syndrome (CPS) are excluded, except for radiographic and surgical services for TMJ and CPS, if Medically Necessary and if there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.
- All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.

Oral Surgery	**PPO In-Network**	**PPO Out-of-Network**	**HDP In-Network**	**HDP' Out-of-Network**
Physician Office Visit	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Hospital	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Surgery Facility Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Organ and Tissue Transplants

Prior Authorization is required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

Transplant-related services must be provided at or arranged by a Transplant Facility designated and approved by the Plan. Contact Member Services at (443) 725-1010 or toll free at (888) 456-2024, for information on designated Transplant Facilities. Transplant Facility means a Hospital providing transplant services under the Plan.

Hospital, surgical and medical services for the following human transplants are covered, provided they meet requirements for the specific transplant surgery:

- Autologous and non-autologous bone marrow transplants
- Cornea
- Heart
- Heart/Lung
- Kidney
- Liver
- Lung (single or double)
- Pancreas
- Pancreas/Kidney
- Small Bowel

Transplant services and supplies include the recipient's medical and surgical services in connection with the transplant including:

- Immunosuppressive medications;
- Organ and tissue search and procurement;
- Harvesting and storage of bone marrow; and
- Pre-transplant evaluation.

In order to be considered as Covered Services, the transplant and the transplant-related services and supplies must meet all of the following requirements:

- All Organ and Tissue Transplant services require Prior Authorization;
- All transplant-related services must be provided at or arranged by a Transplant Facility designated and approved by the Plan;
- The transplant must be Medically Necessary and appropriate for the Member's medical condition;
- The transplant must not be Experimental/Investigational or unproven for the Member's condition.

When both the recipient and the donor are Covered Individuals, each is entitled to the benefits of this Plan.

When only the recipient is a Covered Individual, both the donor and the recipient are entitled to the benefits of this Plan, but the donor benefits are limited to only those not available from any other source to which the donor may have access. Costs of benefits for the donor will be charged against the recipient's coverage under this Plan.

No expenses are payable for a Covered Individual who donates an organ or tissue, unless the person who receives the transplant is a Covered Individual under this Plan.

Organ and Tissue Transplants	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Provider Office Visits	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Hospital	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Orthotics

Orthotics	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Outpatient Services

Outpatient services include, but are not limited to, diagnostic, radiological and laboratory services and Outpatient surgery facility services. See also Physician Services, below.

Outpatient Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Laboratory Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Radiology Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Surgery Facility Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Physician Services

Physician services include:

- Primary care and specialty Health Care Services rendered in an office setting;
- Health Care Services rendered in an Emergency Room or Urgent Care facility; and
- Professional fees for surgeon and necessary assistant surgeon associated with Medically Necessary surgical procedures.

Physician Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Office Visits	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Professional fees associated with: ▪ Inpatient Hospitalization	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Professional fees associated with: ▪ Outpatient Surgical Services	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Emergency Room or Urgent Care physician services when performed in a licensed ER or Urgent Care Facility*	20% of the Allowed Benefit		20% of the Allowed Benefit	

NOTE: Refer to the "Emergency Services and Urgent Care" description in this section for applicable facility services Copays.

Physician Services: Patient-Centered Medical Home Program

***See* Section Two, Part E for information about the Patient-Centered Medical Home program.**

Patient-Centered Medical Home	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Associated Costs for the Patient-Centered Medical Home Program	No Copay or Coinsurance	Not Covered	No Copay or Coinsurance	Not Covered

Prescription Drugs

***See* Part C at the end of this Section Three for more information on the Prescription Drug program.**

To be covered, Prescription Drugs must be approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription, and prescribed by a physician or other Health Care Practitioner authorized to prescribe them by law. Covered Prescription Drugs are subject to Utilization Review by the Plan.

The following equipment and supplies are covered under the Prescription Drug benefit:

- Glucose monitoring equipment (glucometers), insulin syringes, needles, test strips for glucometers and medications for treatment of diabetes. Disposable diabetic supplies are covered at the Generic Drug Copay level when dispensed at a participating Pharmacy.

The Copays listed below are only applicable if the cost of the Prescription Drug is more than the applicable Copay. If the cost of the prescription is less than the applicable Copay, the actual cost of the Prescription Drug must be

paid.

NOTE: For all Benefit Options, except the HDP Benefit Options, there is a separate Prescription Drug Out-of-Pocket Maximum. (*See* Section Three, Part C).

NOTE: Prescription Drug benefits are subject to a $100,000 Prescription Drug Annual Maximum per Member. (*See* Section Three, Part C).

Prescription Drugs	**$200 MHIP+ PPO** (See Note 1 Below)	**$500 MHIP+ PPO** (See Note 1 Below)		**HDP** (See Note 2 Below)
Retail *(31 day supply)*				
Rx Tier 1 – Generic Drug	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Rx Tier 2- Preferred Brand Name Drug	$25 Copay	$45 Copay	$45 Copay	$45 Copay
Rx Tier 3 - Non-Preferred Brand Name Drug	$50 Copay	$75 Copay	$75 Copay	$75 Copay
Rx Tier 4- Select Brand Name Drugs	$75 Copay	$125 Copay	$125 Copay	$125 Copay
Specialty Injectables (Up to one month supply)	**$200 MHIP+ PPO In-Network**	**$500/$1000 PPO In-Network**	**$500/$1000 PPO In-Network**	**HDP In-Network (See Note 2 Below)**
Rx Tier 1 – Generic Drug	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Rx Tier 2 – Preferred Brand Name Drug	$25 Copay	$45 Copay	$45 Copay	$45 Copay
Rx Tier 3 – Non-Preferred Brand Name Drug	$50 Copay	$75 Copay	$75 Copay	$75 Copay
Rx Tier 4-Select Brand Name Drugs	$75 Copay	$125 Copay	$125 Copay	$125 Copay
Maintenance Medications Retail or Mail Order (Up to a 90-day supply)	**$200 MHIP+ PPO In-Network**	**$500/$1000 PPO In-Network**	**$500/$1000 PPO In-Network**	**HDP In-Network (See Note 2 Below)**
Rx Tier 1 – Generic Drug	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Rx Tier 2 - Preferred Brand Name Drug	$50 Copay	$90 Copay	$90 Copay	$90 Copay
Rx Tier 3 - Non-Preferred Brand Name Drug	$100 Copay	$150 Copay	$150 Copay	$150 Copay
Rx Tier 4- Select Brand Name Drugs	$150 Copay	$250 Copay	$250 Copay	$250 Copay

If a Brand Name Drug is requested when a lower-cost Generic Drug is available, the Member will be required to pay the difference in price between the two drugs, *plus* the applicable Preferred Brand Name Drug Copay.

NOTE 1: *If a prescription is filled at a non-participating Pharmacy, 100% of the drug cost must be paid at the time of purchase and a claim form may be submitted for reimbursement. Reimbursement will be based upon the*

network-contracted rate and must be for a medication that is on the preferred drug list without requiring Prior Authorization, or has been authorized by MHIP prior to date of fill and is within the quantity level limit allowed by the Plan.

***NOTE 2:** HDP Benefit Option Members will pay the full cost of Prescription Drugs until the Combined Deductible is met. Once the Combined Deductible has been met, the Member will pay the Copays listed above at a participating Pharmacy. If a prescription is filled at a non-participating Pharmacy after the Combined Deductible is met, 100% of the drug cost must be paid at the time of purchase and a claim form may be submitted for reimbursement. Reimbursement will be based upon the network-contracted rate and must be for a medication that is on the Preferred Brand Name Drug list without requiring Prior Authorization, or has been authorized by MHIP prior to date of fill and is within the quantity level limit allowed by the Plan.*

Preventive Services

The Plan will cover the preventive services at the Copay levels listed below, unless a different Copayment or Coinsurance is specified below, when covered preventive services are provided in-network in connection with an annual physical exam, well child visit, or a preventive screening. With the exception of prostate cancer screening, Members receive Preventative Services at no Copay, if the service is provided by an In-Network Provider.

If a Member receives services for which a $0 Copay does not apply or receives services from an Out-of-Network Provider, the Deductible must be satisfied before services may be received at the Coinsurance rates shown below.

No Deductible applies to the in-network preventive services marked with an asterisk (*) in the table below. Otherwise, the Deductible must be satisfied before receiving services at the Coinsurance rate shown below.

The services, Copayments, and Coinsurances listed below apply only to routine preventive screenings. Members, who have been previously diagnosed with a condition that requires ongoing testing or screening or who need additional Covered Services as a result of a preventive screening, are subject to the Copayment and Coinsurance for those Covered Services stated in this Certificate of Coverage.

The Copayment or Coinsurance rates listed below do not apply to:

- Screenings that are not provided in accordance with the time period limitations listed below or as part of an annual physical exam or well child visit as required below, but rather are provided in connection with the diagnosis of Members presenting symptoms of any disease, disorder, or condition; or
- Treatment of any disease, disorder, or condition diagnosed during a physical exam, well child visit, or preventive screening.

If during an annual physical exam, well child visit, or preventive screening, it is determined that subsequent treatment is necessary, those services are subject to Copayments and Coinsurances as identified in this Certificate of Coverage.

Preventive Services	**PPO In-Network**	**PPO Out-of-Network**	**HDP In-Network**	**HDP Out-of-Network**
Adult Annual Physical Examinations and Preventive Screenings				
Annual Physical Examination (including immunizations) *(1 per Plan Year)**	$0 Copay*	40% of the Allowed Benefit	$0 Copay *	40% of the Allowed Benefit

Preventive Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Adult Immunization(s) (given outside of an annual physical examination) *As recommended by Advisory Committee on Immunization Practices or US Preventative Services Task Force*	No Copay*	40% of the Allowed Benefit	No Copay*	40% of the Allowed Benefit
Abdominal Aortic Aneurysm Screening *(One-time screening by ultrasonography of men aged 65 to 75 who have smoked)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Alcohol Misuse Screening ***(****Coverage limited to an initial screening provided by a Health Care Practitioner in connection with an annual physical examination).*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Behavioral Education in Primary Care to Promote a Healthy Diet *(For adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease)* ***NOTE:*** *Coverage limited to behavioral education provided by a Health Care Practitioner in connection with an annual physical examination.*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Breast Cancer Chemoprevention Screening *(To identify women at high risk of breast cancer and low risk for adverse effects of chemoprevention).*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Cervical Cancer Screening (e.g. pap smear)*(1 per Plan Year)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Chlamydia Screening Test	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit

Preventive Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Colorectal Screening *(Men and Women age 40 years and older)* ▪ *Digital rectal exam (1 per Plan Year)* *(Men and Women age 50 years and over)* ▪ *Fecal occult blood test (1 per Plan Year)* ▪ *Flexible Sigmoidoscopy every 5 years* ▪ *Colonoscopy every 10 years* *Double contrast barium enema every 5 years*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Depression Screening (*Provided in connection with an annual physical examination by a Health Care Practitioner only)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Diabetes Mellitus (Type 2) Screening for Adults *(For adults with hypertension or hyperlipidemia)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Genetic Risk Assessment and BCRA Mutation testing for Breast and Ovarian Cancer Susceptibility (*For women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes*)	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Gonorrhea Screening *(For sexually active women, including pregnant women 25 and younger, or those adults or adolescents at increased risk of infection)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
High Blood Pressure Screening	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
HIV Screening *(For all adolescents and adults at increased risk for HIV infection and all pregnant women)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit

Preventive Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Lipid Disorder (Cholesterol) Screening *(For men 35 and older, women 45 and older, and younger adults with other risk factors for coronary disease)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Mammogram Screening *(At intervals determined to be appropriate by a Health Care Practitioner.)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Obesity Screening in Adults **NOTE:** *Coverage limited to screening provided by a Health Care Practitioner in a primary care setting.*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Osteoporosis Screening ▪ *Bone Mass Measurement* 2 per Plan Year without Prior Authorization for Men and Women age 40 and above	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Prostate Cancer Screening ▪ Digital rectal exam for men *(1 per Plan Year for Men 40 and above)* ▪ PSA Screening for men *(1 per Plan Year)*	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Syphilis Infection Screening *(For persons at increased risk and all pregnant women)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Well Child Examinations and Preventive Services				
Well Child Evaluation with Immunization(s) ▪ *Children over 24 months - 13 years*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Well Child Evaluation with Immunization(s) ▪ *Children older than 13 years of age*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Well Child Evaluation Only *Children 0 -24 months*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit

Preventive Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Well Child Evaluation Only *Children over 24 months*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Iron Deficiency Anemia (Screening and Prevention) *(For asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Prophylactic Medication for Gonorrhea *(for all newborns)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Sickle Cell Disease Screening *(for newborns at risk for sickle cell disease)*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Obesity Screening in Children and Adolescents **NOTE:** *Coverage limited to screening provided by a Health Care Practitioner in a primary care setting.*	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit
Screening for Visual Impairment in Children Ages 1 – 5 Years (Once between ages 3 – 5 years to detect the presence of amblyopia or its risk factors.)	No Copay *	40% of the Allowed Benefit	No Copay *	40% of the Allowed Benefit

Prosthetics

The following internal prosthetics are covered:

- Electronic heart pacemakers, intraocular lenses, and joints; and
- Post-operative breast prostheses following a mastectomy. *See* "Cosmetic and Reconstructive Surgery" in this section.

The following external prosthetics are covered:

- Prosthetic devices such as leg, arm, back or neck braces;
- Artificial legs, arms, or eyes including the initial purchase and replacements due to physical growth for a continuously covered Member and training necessary for use. Artificial limbs are limited to standard items and must be adequate to provide a reasonable level of functionality for normal daily activities; and
- Breast prostheses following a mastectomy.

Repairs, adjustments and duplicates of prosthetics are not covered. Replacements are covered when due to

physical growth for a continuously covered Member.

Prosthetics	PPO In-network	PPO Out-of-network	HDP In-Network	HDP Out-of-Network
	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Rehabilitation Services (Outpatient Therapy)

Rehabilitation Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Physical, speech, or occupational therapy *(Services limited to 30 visits for each therapy per diagnosis per Member per Plan Year)*	30% of the Allowed Benefit	50% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
All other Rehabilitation Services *(Services limited to 30 visits for each therapy per diagnosis per Member per Plan Year)*	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Skilled Nursing Facility

Prior Authorization required. *See* Section Two, Part H - Covered Services Requiring Prior Authorization.

Skilled Nursing Facility Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Skilled Nursing Facility *(Limited to 100 days per Member per Plan Year)*	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

Spinal Manipulation (Chiropractic) Services

Spinal Manipulation (Chiropractic) Services	PPO In-Network	PPO Out-of-network	HDP In-Network	HDP Out-of-Network
Spinal Manipulation (Chiropractic) Services *(Limited to a maximum of 20 visits per person per Member per Plan Year, per diagnosis)*	30% of the Allowed Benefit	50% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit

C. Prescription Drug Program

By enrolling in the Plan, Members are automatically covered under the Prescription Drug program. The Prescription Drug program is administered by the Plan Administrator in cooperation with Argus Health Systems, a Pharmacy claims administrator. Argus Health Systems is an independent company and administers the Prescription Drug

program on behalf of the Plan Administrator. The Prescription Drug program offers the flexibility to purchase medications either at a participating Pharmacy or through a prescription mail order service. The participating Pharmacy network includes most major drug and grocery stores and many smaller, independent pharmacies. All drug forms, quantities and strengths may not be covered or supplied under the Prescription Drug program. The status of some Prescription Drugs may change due to Plan decisions or actions by the Food and Drug Administration (FDA).

Prescription Drug Deductibles

Before the Plan pays for Prescription Drugs, any applicable annual Deductible must be met. Under the PPO Benefit Options, a Member may have a separate Prescription Drug Deductible. The Prescription Drug Deductible is a fixed-dollar amount, designated for Prescription Drug benefits that must be paid before the Plan begins to pay. The Deductible may be satisfied during the full Plan Year depending on when membership in the Plan begins. Under the HDP option, a single Deductible of $2,600 for individuals must be met and a Deductible of $5,200 for families must be met. Both Prescription Drug and medical expenses are combined to meet the Combined Deductible.

NOTE: *Prescription Drug Deductibles and Copays count toward the Prescription Drug Out-of-Pocket Maximum under the PPO Benefit Options. Under the HDP Benefit Option, the entire combined medical and Prescription Drug Deductible will count towards the Medical Benefit Out-of-Pocket Maximum applicable to that Benefit Option.*

Annual Pharmacy Deductible	$200 Deductible PPO	$500 Deductible PPO	$1,000 Deductible PPO	$2,600 HDP
Individual	None	$100	$250	Combined with $2,600 Medical Deductible
Family	None	$100 per Member	$500	Combined with $5,200 Medical Deductible

Prescription Drug Annual Maximum

The Prescription Drug Annual Maximum is the maximum dollar amount of Prescription Drug Covered Services payable by the Plan towards a Member's claims during a Plan Year.

Prescription Drug Annual Maximum (per Member)	$100,000

How the Program Works

Once the Prescription Drug Deductible is satisfied, there are two (2) ways to purchase medications through the Prescription Drug program:

- **Prescription Drugs Taken for Short Durations –** Must be filled at a participating Pharmacy. The MHIP ID card must be presented and the appropriate Copay must be paid for up to a thirty one (31) day (1 month) supply of a prescription. The Pharmacy network includes most major drug and grocery stores and many smaller, independent pharmacies. To verify that a Pharmacy is participating with MHIP, please go to MHIP's website at www.marylandhealthinsuranceplan.state.md.us to see a list of participating pharmacies.

- **Prescription Drugs Taken on an Ongoing/"Maintenance" Basis** (drugs required to be taken for six (6) or more months chronic conditions) – Up to a ninety (90) day (3 month) supply of such medication may be mailed to a residence through the Walgreens mail order program or purchased at a participating Pharmacy. Providers should not request a ninety (90) day supply of medication when the prescription is filled for the first time.

Generic, Preferred Brand Name, Non-Preferred Brand Name and Select Brand Name Drugs

To provide maximum flexibility, the Prescription Drug benefit provides coverage of Prescription Drugs at different levels. The amount that paid out-of-pocket (the Copay) will vary for each of the following categories:

Generic Drugs - A Generic Drug that is approved by the Food and Drug Administration meets the same quality standards as its Brand Name equivalent. Although the color and shape may be different, the active ingredients are the same and are therapeutically equivalent.

Preferred Brand Name Drugs - For flexibility and choice, MHIP includes many Brand Name medications to maximize the Prescription Drug benefit. A Copayment for Preferred Brand Name Drugs may be higher than for Generic Drugs, but less than Non-Preferred Brand Name Drugs.

Non-Preferred Brand Name Drugs - These Brand Name Drugs will generally cost more. Discuss the possibility of using less costly Preferred Brand Name Drug alternatives with a physician and/or Health Care Practitioner.

Select Brand Name Drugs - These are brand name drugs that Plan has selected for placement on Tier 4.

The Copay amount depends on whether the prescribed medication is a Generic, Preferred Brand Name, Non-Preferred Brand Name or Select Brand Name Drugs and the Member's MHIP Benefit Option. If a Brand Name Drug was requested when a lower-cost generic equivalent is available, the Member will be required to pay the difference in price, *plus* the applicable Copay.

Prior Authorization

Some drugs require Prior Authorization in advance of being dispensed. Please refer to the MHIP website at www.marylandhealthinsuranceplan.state.md.us for a list of drugs requiring Prior Authorization. The physician or Health Care Practitioner must call Argus Health Systems at (800) 314-2872 and submit any required information by phone or fax before prescribing these medications.

- The Pharmacy will not be able to fill the prescription before the Health Care Practitioner obtains Prior Authorization for a drug requiring Prior Authorization.

- A Health Care Practitioner must call Argus Health Systems at (800) 314-2872 and submit any required information by phone or fax before prescribing these medications. Argus Health Systems will review the required information and make a decision to approve or, deny or with a potential recommendation for an alternative to the requested drug.

- If the Prescription Drug is approved, Argus Health Systems will enter an authorization enabling the local Pharmacy to fill the prescription for the drug. The Health Care Practitioner will receive notification of the approval from Argus Health Systems.

- If the requested drug is denied, the Member and the Member's Health Care Practitioner will receive verbal and written notification describing options for Appealing the denial.

For questions about this process, contact Member Services at (443) 725-1010 or toll free at (888) 456-2024 or contact Argus Health Systems at (800) 241-3371.

Quantity Limits

Some prescribed medications covered under MHIP have quantity limitations. Quantity limits means that only a set number and/or dosage per prescription is allowed based on clinically approved prescribing guidelines to ensure safety. If a drug outside of established quantity limits is prescribed, Argus Health Systems at (800) 314-2872 must be contacted.

Please refer to the MHIP website at www.marylandhealthinsuranceplan.state.md.us for the most up-to-date list of drug quantity limits. This list is also available by contacting Member Services at (443) 725-1010 or toll free at (888) 456-2024.

Using the Pharmacy Network

When a prescription needs to be filled, the Pharmacist will need to see the Member's MHIP ID card. Applicable Copays will apply once the Prescription Drug Deductible has been met. Please refer to the MHIP website at www.marylandhealthinsuranceplan.state.md.us for Pharmacy locations.

If a prescription is filled at a non-participating Pharmacy, 100% of the drug cost must be paid at the time of purchase and a claim form for reimbursement may be submitted. Direct Reimbursement Claim Forms are available on the MHIP website at www.marylandhealthinsuranceplan.state.md.us or by contacting Member Services at (443) 725-1010 or toll free at (888) 456-2024. *See* Section Two, Part M - Filing a Claim.

Reimbursement will be determined by prescription benefit coverage and Prior Authorization requirements.

Using the Mail Order Program

The mail order Prescription Drug program, provided by Walgreens, is an integrated feature to the Pharmacy benefits. It is a convenient way to order medications through the mail. A prescription is reviewed and dispensed by a registered Pharmacist and is mailed directly to a Member's home. The mail order program can provide up to a ninety (90) day supply of medications for two (2) Copays. It is recommended that prescriptions for short-term medications be obtained from a participating retail Pharmacy. Contact Walgreens Mail Order Service at 800-745-6285 for more information.

When a prescription for a maintenance drug needs to be filled immediately for a medication to be taken on an ongoing basis, two (2) prescriptions should be requested for a thirty four (34) day supply that can be filled immediately at a local Pharmacy and a ninety (90) day supply, plus refills, if appropriate, that can be sent to Walgreens immediately.

In order to use the Walgreens mail order program, register with Walgreens Mail Service:

- **By mail**. Complete a "Registration & Prescription Order Form" that can be obtained by visiting www.walgreenshealth.com and submit the form along with the prescription and any Copay to:

  Walgreens Mail Service
  PO Box 628001
  Orlando, FL 32862-8001

- **On-Line**. Register via the internet by visiting www.walgreensmail.com/carefirst. Complete and submit the required information. On-line registration may take up to 48 hours to become active. After completing on-line registration, Walgreens may be called at 800-745-6285 to order prescription refills. The following information will need to be provided to Walgreens:
  - ► Prescription Benefit Provider:……CareFirst BlueCross BlueShield.
  - ► Member ID Number:……..……Up to 10 digits found on ID card
  - ► Group Number:……..03000000
  - ► Mail Services Pharmacy:…….Orlando, FL

- **Via Fax from Doctor's Office.** Register by using the Walgreens Doctor Fax Order Form available from www.walgreensmail.com/carefirst. Fill out the Member/Patient areas on the right hand side of the form. The doctor must fill out the prescription information and he or she can fax the form directly to Walgreens Mail Services. Please note that, to be valid, the Doctor Fax Order Form **must** be faxed from the doctor's office.

- **By Phone.** Call Walgreens Mail Services at (800) 745-6285 to register. After registering by phone, ask the Member Services Representative to process the prescription refill, if needed. A credit card number is required for any applicable Copay.
  NOTE: Please allow two (2) weeks from the time an order is mailed, faxed or placed for delivery.

Walgreens Mail Services has four (4) refill options:

- Touch-tone: (800) 749-0009, 24 hours a day, 7 days-a-week
- Internet: www.walgreenshealth.com 24 hours a day, 7 days-a-week
- Telephone: Contact a Member Services Representative at (800) 745-6285

- Mail: Mail the refill request slip provided in each order. When submitting a mail order for maintenance prescription obtained through the mail service, mail the prescription to:

Walgreens Mail Service
PO Box 628001
Orlando, FL 32862-8001

Special Restrictions - Narcotics are not available through the mail order program. Some medications are limited in the amount that can be supplied at any one time; therefore, a ninety (90) day supply may not be available. In these cases, no more than the amount allowed will be provided. The Copay will cover only the supply that can be sent at any one time. Prescription Drugs are not available when the same drug is available Over-the-Counter. A Prescription Drug is considered to be the same as an Over-the-Counter medication if the Prescription Drug has the same ingredients, in the same concentration as the Over-the-Counter drug.

Member Services
Toll-free numbers are available for inquiries about Prescription Drug benefits. Calls are handled by representatives who have been formally trained to answer inquiries. For questions regarding Prescription Drug benefits, call the following toll-free numbers for assistance.

- *Retail Pharmacy Program (Argus Health Systems)*: (800) 241-3371 Monday through Friday, 8:30 a.m. to 12:00 midnight, and Saturday from 8:00 a.m. to 6:00 p.m., Eastern Time. Emergency Pharmacy consultation is available seven days a week, 24 hours a day.
- *Mail Order Program (Walgreens)*: (800) 745-6285
- *Mail Order Program Number for the Hearing-Impaired*: (800) 863-5488
- *For Vision-Impaired Members*: Upon special request with a mail order, the Pharmacist will provide Braille labels for medication vials.

D. Mental Health and Substance Abuse Services

Mental Health and Substance Abuse Services for MHIP are administered by the Plan Administrator in cooperation with Magellan Health Services ("Magellan"), an independent company. All inquiries regarding the Mental Health and Substance Abuse services, except requests for Prior Authorization, should be directed to Member Services at (443) 725-1010 or toll free at (888) 456-2024. To obtain Prior Authorization, when required, for Mental Health and Substance Abuse services, when required, call Magellan Health Services at (800) 245-7013. Magellan's core business hours are 8 a.m. to 6 p.m., Monday to Friday; however, Magellan is available 24 hours a day, 7 days a week for urgent/emergency issues.

Members must call Magellan Health Services at (800) 245-7013 and obtain Prior Authorization prior to receiving Inpatient Mental Health or Substance Abuse services. Any and all information relating to a Member's health care history, diagnosis, condition, treatment, or evaluation is kept confidential.

Emergency Services: In the event of a crisis, call Magellan's toll-free number, (800) 245-7013, 24 hours a day 7 days a week. For life threatening emergencies, call 911 to access emergency services.

What Is Not Covered By The Plan

For questions about whether a service is excluded, contact Member Services at (443) 725-1010 or toll free at (888) 456-2024.

The Plan will not pay for expenses incurred for the following:

1. Services that are not Medically Necessary;
2. Services performed or prescribed under the direction of a person who is not a Health Care Practitioner;
3. Services that are beyond the scope of practice of the Health Care Practitioner performing the service;
4. Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable;
5. Services that do not legally, nor as a customary practice, require payment in the absence of a health benefit plan;
6. Routine vision care or examinations (except where specified in Section Three (Covered Services)) or the purchase, examination, or fitting of eye glasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury;
7. Personal care services and domiciliary care services;
8. Services rendered to a Member by a Health Care Practitioner who is the Member's spouse, mother, father, daughter, son, brother or sister;
9. Experimental/Investigational services or drugs or Prescription Drugs prescribed or dispensed for Experimental/Investigational purposes;
10. Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error;
11. In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures. Artificial insemination is excluded;
12. Services to reverse a voluntary sterilization procedure;
13. Services for sterilization or reverse sterilization for a Dependent minor;
14. Surgical treatment for obesity;
15. Medical treatment, surgical treatment, pharmacological treatment or regimen for reducing or controlling weight;
16. Services incurred before the Effective Date of coverage;
17. Services incurred after termination of coverage, except as provided in any extension of benefits;
18. Surgery or any related physician services for Cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies;
19. Services for job-related injuries or diseases to the extent that the Member is required to be covered by a workers' compensation law;
20. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups;
21. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, furniture, or physical fitness equipment;
22. Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form;
23. Inpatient admissions primarily for diagnostic studies, unless authorized by the Plan;
24. The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as provided in Section Three (Covered Services) in this Certificate;
25. Except for covered ambulance services, travel, whether or not recommended by a Provider;
26. Except for emergency services, services rendered while the Member is outside the United States;
27. Immunizations related to foreign travel;
28. Unless otherwise specified in Section Three (Covered Services), any type of dental care, work or treatment which includes, but is not limited to, routine examination or cleaning of the teeth, extractions of teeth, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, false teeth, or any other Hospital, professional care, or dental services or supplies in connection with:
    - The operation or treatment for the fitting or wearing of dentures;
    - Orthodontic care or malocclusion;

- Dental implants; and
- Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for:
  - ► Removal of tumors and cysts; or
  - ► Treatment of injury to natural teeth due to an accident if the treatment is received within six (6) months of the accident;

29. Accidents occurring while and as a result of chewing;
30. Routine foot care, including the paring and removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary;
31. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary for rehabilitation or habilitation purposes;
32. Inpatient admission primarily for physical therapy, unless authorized by the Plan;
33. Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery;
34. Treatment of sexual dysfunction not related to organic disease;
35. Services that duplicate benefits provided under federal, state or local laws, regulations, or programs;
36. Organ transplants, except for those included in Section Three (Covered Services) in this Certificate;
37. Non-human organs and their implantation;
38. Non-replacement fees for blood and blood products;
39. Lifestyle improvements, including nutrition counseling or physical fitness programs, unless included as a Covered Service;
40. Wigs or cranial prostheses;
41. Weekend admission charges, except for emergencies and maternity, unless authorized by the Plan;
42. Out-patient orthomolecular therapy, including nutrients, vitamins, and food supplements;
43. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for radiographic and surgical services for TMJ and CPS, if Medically Necessary and if there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury;
44. Services for conditions that state or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution;
45. Services for, or related to, the removal of an organ from a Member for purposes of transplantation into another person, unless the recipient is covered under the Plan and undergoing a covered transplant;
46. Physical examinations required for obtaining or continuing employment, insurance, or government licensing;
47. Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;
48. Private Hospital rooms, unless authorized by the Plan;
49. Private duty nursing, unless authorized by the Plan;
50. Treatment for Mental Health or Substance Abuse that requires Prior Authorization that is not authorized by the Plan Administrator, or for a Mental Health or Substance Abuse condition determined by the Plan Administrator to be untreatable;
51. Services related to smoking cessation;
52. Acupuncture;
53. Rest cures, residential, convalescent, or custodial care in a group home, halfway house or residential setting;
54. Marital counseling, educational therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy;
55. Pastoral counseling;
56. Psychological testing for educational purposes;
57. Hypnosis for non-Diagnosis and Statistical Manual (DSM) classified disorders;
58. Treatment of conditions without recognizable DSM diagnostic classification (such as adult child of alcoholic families, “ACOA,” “co-dependency”);
59. Over-the-Counter medications and Prescription Drugs that have the same ingredients, in the same concentration, as an Over-the-Counter medication;
60. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
    - prenatal vitamins.
    - fluoride and fluoride containing vitamins.
    - single entity vitamins, such as Rocaltrol and DHT.
61. Prescription Drugs for Cosmetic use;
62. Prescription Drugs for weight loss;

Section Four- Exclusions: Services Not Covered by the Plan

63. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation program designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work; and
64. Any service not specified as a Covered Service in Section Three of this Certificate.

MHIP Member Rights and Responsibilities

- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to receive information about the Plan, its services, its practitioners and Providers, and Members' rights and responsibilities.
- Members have a right to participate with practitioners in decision making regarding their health care.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to make recommendations regarding the Plan's Members' rights and responsibilities policy.
- Members have a right to voice complaints or Appeals about the Plan or the care provided.
- Members have a responsibility to provide, to the extent possible, information that the Plan and its practitioners and Providers need in order to care for them.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Members have a responsibility follow the plans and instructions for care that they have agreed on with their Providers.
- Members have a responsibility to pay Member Copayments or Coinsurances at the time of service.
- Members have a responsibility to keep and be on time for appointments and to notify Providers when an appointment must be cancelled.
- Members have a responsibility to notify the Plan immediately if they have or become eligible for Medicare, Medicaid or any other health insurance.
- Members have a responsibility to notify the Plan if they relocate out of state.
- Members have a responsibility to keep their MHIP ID card with them and to present it to a Health Care Practitioner or a Health Care Facility at the time of service.

Section Six – Definitions

The definitions in this section are for terms used in this Certificate.

Accidental Injury – Bodily injury resulting from a sudden, violent, unexpected, and external event. Accidental Injury does not include poisoning, disease, or any type of infection.

Adverse Benefit Determination – For purposes of Section Two, Part N, any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Adverse Decision – For purposes of Section Two, Part N, a utilization review determination that:

a. A proposed or delivered health care service covered under the Member's contract is or was not Medically Necessary, appropriate, or efficient; and

b. May result in non-coverage of the health care service. Adverse Decision does not include a Coverage Decision.

Allowable Expenses - *See* definition in Section Two, Part O – Coordination of Benefits.

Allowed Benefit -

For a Preferred Provider, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered, except for facilities that are paid in accordance with Diagnosis Related Groups ("DRG's"). The benefit is payable to the Provider and is accepted as payment in full, except for any applicable Deductible, Copayment, and Coinsurance amounts, for which the Member is responsible.

For a Non-Preferred Provider other than a Health Care Facility, the Allowed Benefit for a Covered Service is determined in the same manner as the Allowed Benefit for a Preferred Provider. The benefit is payable to the Member or to the Provider, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts and for the difference between the Allowed Benefit and the Practitioner's actual charge. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Health Care Practitioner.

For a Non-Preferred Provider that is a Health Care Facility, the Allowed Benefit for a Covered Service may be a rate set by a regulatory agency and is no less than the allowed amount paid to a similarly licensed provider who is a Preferred Provider that is a Health Care Facility for the same health care service in the same geographic region. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an Eligible Provider. In that instance, the CareFirst payment will be based on the negotiated fee and the Eligible Provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits, for which the Member is responsible. The benefit is payable to the Member or to the Non-Preferred Provider at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred

Provider. In any event, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless the fee is negotiated, for any Balance Bill.

For a Prescription Drugs, the Allowed Benefit for covered Prescription Drugs is the lesser of:

- The Pharmacy's actual charge; or
- The benefit amount, according to the Plan's fee schedule, for covered Prescription Drugs that applies on the date that the service is rendered.

If the Member purchases a covered Prescription Drug or Diabetic Supply from a participating Pharmacy, the benefit payment is made directly to the participating Pharmacy and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance as stated in this rider. The Member is responsible for any applicable Deductible, Copayment or Coinsurance and the participating Pharmacy may bill the Member directly for such amounts.

If the Member purchases a covered Prescription Drug or Diabetic Supply from a non-participating Pharmacy, the Member is responsible for paying the total charge and submitting a claim to the Plan for reimbursement. Members will be entitled to reimbursement from the Plan up to the amount of the Allowed Benefit, minus any applicable Deductible, Copayment or Coinsurance. Members may be responsible for balances above the Allowed Benefit.

Alternate Recipient - A child of a Subscriber who is recognized under a qualified medical child support order (QMCSO) as having a right to enrollment under the Plan.

Annual Maximum – *See* Prescription Drug Annual Maximum.

Appeal - For purposes of Section Two, Part N, a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan under its internal appeal process regarding a Coverage Decision.

Appeal Decision – For purposes of Section Two, Part N, A final determination by the Plan that arises from an Appeal.

Benefit Option – One of the following Plan options authorized by the MHIP Board of Directors:

- $200 Deductible PPO (Only available to qualified MHIP+ Members)
- $500 Deductible PPO
- $1,000 Deductible PPO
- $2,600 High Deductible Plan (HDP).

Brand Name Drug – A Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and that may be used and protected by a trademark.

Care Coordination Team - The Health Care Practitioners involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan - The plan directed by a Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the Patient-Centered Medical Home goals and objectives.

Section Six – Definitions

Claim for Benefits – For purposes of Section Two, Part N, a request for a Plan benefit or benefits made by a Member in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

Claim Involving Urgent Care - For purposes of Section Two, Part N, any claim for medical care or treatment that involves an Emergency Case or an Urgent Medical Condition. Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Member's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

Claims Procedures - For purposes of Section Two, Part N, collectively, the procedures governing the filing of benefit claims, Notification of benefit determinations, and Grievances and Appeals of Adverse Benefit Determinations for Members.

Commissioner – The Commissioner of the Maryland Insurance Administration.

Compelling Reason - For purposes of Section Two, Part N, a showing that the potential delay in receipt of a health care service until after the Member, the Member's Representative or Health Care Provider acting on behalf of the Member exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Member remaining seriously mentally ill with symptoms that cause the Member to be in danger to self or others.

COBRA Coverage – Employer health coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, for which the full cost must be paid in order to extend coverage as a result of certain qualifying events, such as termination of employment or divorce.

Coinsurance – The percentage of the Allowed Benefit allocated between the Plan and the Member whereby the Plan and the Member share in the payment for Covered Services.

Combined Deductible - The dollar amount of the Allowed Benefit for medical and Prescription Drug Covered Services that must first be incurred by the Member of the HDP Benefit Option during a Plan Year before the Plan will make payments for Covered Services. (See Section Three, Part A – Plan Year Deductibles, Out-of-Pocket Maximums, Prescription Drug Annual Maximums and Lifetime Maximums.).

Complaint – For purposes of Section Two, Part N, a protest filed with the Maryland Insurance Commissioner involving an Adverse Decision, Coverage Decision, Appeal Decision or Grievance Decision.

Controlled Clinical Trial – Treatment that is approved by an institutional review board; conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and approved by an institution or center of the National Institutes of Health, the Food and Drug Administration, the Department of Veterans' Affairs, or the Department of Defense.

Copayment/Copay – The dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Provider, the Member will only be responsible for one Copayment.

Cosmetic – The use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by the Plan.

Section Six – Definitions

Coverage Decision - For purposes of Section Two, Part N:

a. An initial determination by the Plan or the Plan's Designee that results in non-coverage of a health care service;

b. A determination by the Plan that that an individual is not eligible for coverage under the Certificate of Coverage; or

c. A determination by the Plan that results in the Rescission of an individual's coverage under the Certificate of Coverage;

A Coverage Decision includes nonpayment of all or part of a Claim for Benefits. A Coverage Decision does not include an Adverse Decision or a Pharmacy Inquiry.

Covered Individual – A Member and any Dependent(s) covered under this Plan.

Covered Services – Medically Necessary Health Care Services and supplies provided by or through the Plan, subject to all Plan terms, conditions, limitations, and exclusions.

Deductible – The dollar amount of the Allowed Benefits for Covered Services that must first be incurred by the Member during a Plan Year before the Plan will make payments for Covered Services.

Deductible Carryover – A credit for charges that can be applied to a Plan Year medical and/or Prescription Drug Deductibles if a Member is enrolled in any of the PPO Benefit Options, but not the HDP Benefit Option. Any expenses incurred during the 4th quarter of the Plan Year (April 1 – June 30) that apply to a current Plan Year Deductible, will be applied (or carried over) toward the Deductible for the next Plan Year.

Dependent – Dependent includes:

- A lawful spouse;
- An unmarried, biological child, step-child or foster child under age 26;
- A lawfully adopted, unmarried child (or child in the process of being adopted) under age 26, as of the date of placement for adoption;
- An unmarried child who is under age 26 for whom the Subscriber has been granted legal custody, including custody as a result of guardianship, other than a temporary guardianship of less than twelve (12) months duration, that is granted by a court or testamentary appointment;
- An unmarried child under age 26 for whom the Subscriber is legally obligated to provide coverage pursuant to court order, court-approved agreement, or testamentary appointment; and
- An unmarried child over age of 26, who is incapable of self-support, because of mental or physical incapacity that began prior to the age of 26 and who resides at the home of the Subscriber and relies on the Subscriber for material support.

Designee of the Commissioner - Any person to whom the Commissioner has delegated the authority to review and decide Complaints, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

Effective Date – A Subscriber's beginning date of coverage under the Plan, including, but not limited to, the beginning date of coverage under an MHIP+ Benefit Option.

Emergency Case – For purposes of Section Two, Part N, medical services are necessary to treat a condition or illness that, without immediate medical attention, would either (i) seriously

jeopardize the life or health of the Member or the Member's ability to regain maximum function, or (ii) cause the Member to be in danger to self or others.

Emergency Services - Care provided after the sudden and unexpected onset of a medical condition of sufficient severity, including severe pain, when the absence of immediate medical attention could reasonably be expected by a prudent layperson that possesses an average knowledge of health and medicine to result in:

- Serious jeopardy to the mental or physical health of the individual; or
- Danger of serious impairment of the individual's bodily functions; or
- Serious dysfunction of any of the individual's bodily organs; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst determines.

Experimental/Investigational – A service or supply that is in the developmental stage and in the process of human or animal testing, excluding Controlled Clinical Trials. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

- The Technology* must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
- The Technology must improve the net health outcome;
- The Technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques. A drug is not considered Experimental/Investigational as long as it is used to treat a covered indication; it has been approved by the FDA for at least one indication; and, it is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer review medical literature.

Filing Date – For purposes of Section Two, Part N, the earlier of (i) five (5) days after the date of mailing; or (ii) the date of receipt.

Generic Drug – means any Prescription Drug approved by the FDA that has the same bio-equivalency as a specific Brand Name Drug.

Grace Period – The Grace Period is the end of the month following the date on which a Member's Premium is due.

Grievance -For purposes of Section Two, Part N, a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member through the Plan's internal Grievance process regarding an Adverse Decision.

Grievance Decision – For purposes of Section Two, Part, N, a final determination by the Plan that arises from a Grievance.

Health Advocacy Unit – For purposes of Section Two, Part N, the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article, Annotated Code of Maryland.

Health Care Facility - A Hospital, ambulatory surgical facility or center, Inpatient rehabilitation facility, home health agency, skilled nursing facility, hospice facility, hospice program or Partial

Hospitalization program that is licensed or certified, or both, to operate within the jurisdiction in which it is located.

Health Care Provider – For purposes of Section Two, Part N means:

a. An individual who is licensed under the Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Member; or

b. A hospital as defined in Title 19 Subtitle 3 of the Health-General Article.

Health Care Practitioner – A physician, dentist (D.D.S. or D.M.D.) or other licensed provider of health care such as: a chiropodist, chiropractor, doctor of podiatry, doctor of surgical chiropody, nurse anesthetist, nurse midwife, nurse practitioner, optician, optometrist, physical therapist, physiotherapist, audiologist, psychologist and social worker.

Health Care Service – A health or medical care procedure or service rendered by a Health Care Practitioner or Health Care Facility, including:

- Testing, diagnosis, or treatment of a human disease or dysfunction; and,
- Dispensing drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

Health Insurance Portability and Accountability Act (HIPAA) – A federal law that among other things, limits the use of Pre-Existing Condition exclusions, waiting periods, and health status exclusions. HIPAA also regulates an organization's policies and procedures covering the privacy of, and access to, patient health information.

High Deductible Plan (HDP) - A Benefit Option that allows a Member to choose medical care from either in-network or out-of-network Providers, and use a tax-advantaged federal Health Savings Account (HSA) to pay for certain out-of-pocket Plan claim expenses, as permitted by the IRS.

Home Health Care – The Health Care Services provided during a visit by a Home Health Agency to patients confined at home due to an Illness or injury requiring skilled Health Care Services on an intermittent, part-time basis.

Hospice – An agency or organization that administers a program of palliative and supportive Health Care Services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a life expectancy of six (6) months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (Outpatient hospice services) or in a home-like setting (Inpatient Hospice services), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family.

Hospital - Any facility in which the primary function is the provision of diagnosis, treatment, and medical and nursing services, surgical or non-surgical and that is:

- Licensed by the appropriate State authorities; or
- Accredited by the Joint Commission on Accreditation of Healthcare Organizations; or,
- Approved by Medicare.

Household Income – The sum of income received in the calendar year by all household members age fifteen (15) years and older, including household members not related to the householder. Included in the total income are amounts reported separately for wage or salary income, unemployment compensation, self-employment income, interest, dividends, rental

income, income from estates and trusts, Social Security or Railroad Retirement income, Supplemental Security Income (SSI), public assistance or welfare payments, retirement survivor income or disability pensions and all other income.

Illness – For purposes of this Plan, an Illness is a bodily disorder or disease, mental illness, substance abuse, accidental bodily injury, or pregnancy. All Accidental Injuries sustained by an individual in a single accident, or all Illnesses that are due to the same or related cause are considered as one Illness.

Inpatient – An admission to a Hospital as a bed-patient in which Room and Board Charges are incurred.

Intensive Outpatient – A treatment program offering a coordinated plan of clinical services and modalities delivered in an Outpatient ambulatory setting.

Lifetime Maximum - The maximum dollar amount of medical and Prescription Drug Covered Services payable by the Plan toward a Member's claims during a Member's lifetime.

Maintenance Drug – A Maintenance drug is a Prescription Drug anticipated by a health care prescriber to be required for six (6) months or more to treat a chronic condition.

Medical Necessity or Medically Necessary – Health Care Services or supplies that a Health Care Practitioner, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, injury, disease or its symptoms. These Health Care Services or supplies are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's Illness, injury or disease;
- Not primarily for the convenience of the patient, physician or other Health Care Practitioner; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's Illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of Health Care Practitioners practicing in relevant clinical areas, and any other relevant factors.

The fact that a Health Care Practitioner may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by this Certificate of Coverage. Medical Necessity is determined by the Plan.

Medicare – Medical benefits provided by Title XVIII of the Social Security Act of 1965, as amended from time to time.

Medicaid – A federally-funded, state-operated and administered program authorized by Title XIX of the Social Security Act of 1965, as amended from time to time.

Medically Uninsurable Individual- An individual who is a Maryland Resident and who:

- Provides evidence that, for health reasons, a carrier has refused to issue substantially similar coverage to the individual;

- Provides evidence that, for health reasons, a carrier has refused to issue substantially similar coverage to the individual, except at a rate that exceeds the Plan rate;
- Satisfies the definition of "eligible individual" under Insurance Article Section 15-1301, Annotated Code of Maryland;
- Has a history of or suffers from a medical or health condition that is included on a list promulgated by the Board via regulation;
- Is eligible for the tax credit for health insurance costs under Section 35 of the Internal Revenue Code; or
- Is a Dependent of an individual who is eligible for coverage under the Plan.

"Medically Uninsurable Individual" does not include an individual who is eligible for coverage under:

- The federal Medicare program;
- The Maryland Medical Assistance Program (Medicaid);
- The Maryland Children's Health Program; or
- An employer-sponsored group health insurance plan that includes benefits comparable to Plan benefits, unless the individual is eligible for the tax credit for health insurance costs under Section 35 of the Internal Revenue Code and an employer pays less than 50% of the cost of the coverage. This does not include a person who is eligible for employer-sponsored group health insurance, but is unable to activate such coverage during a mandatory initial waiting period.

Maryland Resident - An individual who maintains his or her legal residence in the State of Maryland. Legal residence is the principal address where the individual resides, receives mail, and uses on a driver's license, any other government-issued identification card, tax returns, and any other government or important documents during the Plan Year.

Member – For purposes of Section Two, Part N, an individual insured by the Plan, whether the Subscriber or eligible Dependent(s), having effective coverage under the Plan.

Member's Representative - For purposes of Section Two, Part N, an individual who has been authorized by a Member to file a Grievance, Appeal or a Complaint on behalf of a Member.

Member Services Department – The Plan Administrator's Member Services Department.

Mental Health – Counseling, psychological, psychiatric, Substance Abuse, or other treatments for conditions related to mental illness and/or Substance Abuse.

MHIP Application – The Maryland Health Insurance Plan Enrollment Application Form.

MHIP Board of Directors – The Board of Directors of the Maryland Health Insurance Plan.

MHIP+ - See Premium Subsidy Program.

MHIP Master Plan – The Master Plan adopted for the Plan and filed with the Maryland Insurance Administrator by the MHIP Board of Directors.

Non-Preferred Brand Name Drug – A drug that the Plan has not designated as a Preferred Brand Name Drug.

Non-Preferred Provider - A Health Care Facility or Health Care Practitioner that has not entered into a written agreement to render Covered Services to a Member in accordance with the terms and conditions of the Plan.

Section Six – Definitions

Notice or **Notification** – For purposes of Section Two, Part N, the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

Oldest Covered Member -

Open Enrollment – The designated month each year in which a Member may elect to transfer from one MHIP Benefit Option or Type of Coverage to another.

Orthotic (Appliance or Device) – A type of corrective appliance designed to support a weakened body part, including, but not limited to specially designed corsets, leg braces, and extremity splints.

Outpatient – Service for a diagnosis or treatment at a Health Care Facility or physician's office that does not incur room and board charges.

Over-the-Counter – Any item or supply, as determined by the Plan, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-The-Counter medications and solutions.

Partial Hospitalization – Intensive treatment in a medically supervised setting with the opportunity for the Member to return home or to another residential setting at night. Services are usually offered three (3) to five (5) times per week for more than several hours per day.

Partial Mental Health Hospitalization (PHP) – A facility based Outpatient service. Programming for this level of care lasts 6-8 hours per day, 3-5 days per week. Patients at this level of care will participate in individual and group counseling, and will have regular (if not daily) contact with a psychiatrist for medication management.

Patient-Centered Medical Home Program ("PCMH") - Medical and associated services directed by the PCMH team of medical professionals to:

- Foster the Health Care Practitioner's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;
- Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and,
- Exchange medical information with CareFirst, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.

Pharmacist - An individual licensed to practice Pharmacy regardless of the location where the activities of practice are performed.

Pharmacy - An establishment in which prescription or nonprescription drugs or devices are compounded, dispensed, or distributed.

Pharmacy Inquiry – For purposes of Section Two, Part N, an inquiry submitted by a Pharmacist or Pharmacy on behalf of a Member to the Plan, Plan Designee or Pharmacy benefits manager at the point of sale about the scope of Pharmacy coverage, Pharmacy benefit design, or formulary under the Plan.

Plan – The Maryland Health Insurance Plan (MHIP), and its agents, employees, business associates, and contractors, include any sub-contractor of a business associate or contractor.

Section Six – Definitions

MHIP is a state-administered health program operating as an independent agency of the Maryland Insurance Administration under the direction of the MHIP Board of Directors.

Plan Administrator – CareFirst BlueCross BlueShield which is the entity contracted with MHIP as the third party administrator of the Plan under COMAR 31.17.01.03.

Plan Designee – For purposes of Section Two, Part N, CareFirst.

Plan Year – The twelve (12) consecutive months beginning July 1st and ending on June 30th.

Post-Service Claim - For purposes of Section Two, Part N, any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim - For purposes of Section Two, Part N, any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Pre-Existing Condition – A medical condition that has been diagnosed, for which care or treatment has been received or for which care of treatment has been recommended within the six (6) month period immediately prior to the Plan Effective Date.

Preferred Brand Name Drug – A Prescription Drug that the Plan has designated on its preferred drug list.

Preferred Provider - A Preferred Facility or a Preferred Practitioner, as defined below.

- **Preferred Facility** - A Health Care Facility that has entered into a written agreement to render Covered Services to a Member in accordance with the terms and conditions of the Plan.
- **Preferred Practitioner** - A Health Care Practitioner that has entered into a written agreement to render Covered Services to a Member in accordance with the terms and conditions of the Plan.

Preferred Provider Organization (PPO) – Three Benefit Options ($200 Deductible (for MHIP+ Members only), $500 Deductible, and $1,000 Deductible) that allow a Member to obtain Covered Services from either in-network or out-of-network Providers. Out-of-pocket expenses will vary depending on whether care is sought from in-network or out-of-network Providers.

Premium – The monthly sum due to the Plan from Subscribers and Members in order for coverage under the Plan remain in force.

Premium Subsidy Program – The Maryland Health Insurance Plan Premium Subsidy Program is also known as MHIP+. MHIP+ is a program that provides low to moderate-income MHIP Members with Premium assistance. The program is only available to those Members whose household income is at or below 300% of Federal income guidelines.

Prescription Drug A drug, biological, or compounded prescription dispensed by a Pharmacist or Pharmacy intended for administration or use by the Member that carries the FDA legend “may not be dispensed without a prescription;” and, drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature. For purposes of this Certificate, Prescription Drug includes the diabetic equipment and supplies described in the Prescription Drugs section of the Schedule of Benefits and does not include blood or blood products described in the Blood & Blood Products section of the Schedule of Benefits. See Section Three, Part B – Schedule of Benefits.

Section Six – Definitions

Prescription Drug Annual Maximum – The Prescription Drug Annual Maximum is the maximum dollar amount of Prescription Drug Covered Services payable by the Plan towards a Member's claims during a Plan Year.

Prior Authorization – The approval a Member, or Provider acting on a Member's behalf, must seek and receive in advance from the Plan in order for services or Prescription Drugs that require Prior Authorization to be Covered Services. Prior Authorization includes Utilization Review. See Section Two, Parts G (Prior Authorization Requirements) and H (Covered Services Requiring Prior Authorization).

Provider – A Health Care Practitioner, Health Care Facility or any other person or entity licensed or otherwise authorized by law to provide Health Care Services.

Qualifying Individual - a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the Patient-Centered Medical Home Program.

Relevant – For purposes of Section Two, Part N, a document, record, or other information shall be considered Relevant to a Member's claim if such document, record, or other information:

a. Was relied upon in making the benefit determination;

b. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

c. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or

d. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Rescission – For purposes of Section Two, Part N, a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions towards the cost of coverage.

Select Brand Name Drugs – Brand name drugs that the Plan has selected for placement on the fourth Copayment tier.

Specialist - A licensed physician who is certified or eligible for certification by the appropriate specialty board and trained in practice in a specified field of medicine.

Subscriber – The primary Member responsible for Premium payment and whose eligibility is the basis for participation in the Plan.

Substance Abuse – An Illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverage. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or social or economic function is substantially disrupted.

Section Six – Definitions

Substantially Similar Coverage – Coverage under any health plan providing Hospital, medical, or surgical benefits on an expense incurred basis issued by an insurer, by a nonprofit health service plan, a health maintenance organization, or an employer-sponsored plan that provides health benefits to the employees of the employer.

Transplant Facility – A Hospital providing transplant services under the Plan.

Type of Coverage - One of the following Types of Coverage authorized by the MHIP Board of Directors:

- **Subscriber Only** – MHIP will cover only the Subscriber.
- **Subscriber and Spouse** – MHIP will cover the Subscriber and the Subscriber's spouse.
- **Subscriber and Child(ren)** – MHIP will cover the Subscriber and one or more unmarried Dependent children.
- **Subscriber and Family** – MHIP will cover the Subscriber, the Subscriber's spouse, and any unmarried Dependent children.

Urgent Care – Medical treatment for conditions that require prompt medical attention, but are not life-threatening emergencies.

Urgent Medical Condition – For purposes of Section Two, Part N, a condition that satisfies either of the following:

a. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

   i. Placing the member's life or health in serious jeopardy;

   ii. The inability of the member to regain maximum function;

   iii. Serious impairment to bodily function;

   iv. Serious dysfunction of any bodily organ or part; or

   v. The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

b. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

Utilization Review – The Prior Authorization process by which the Plan determines whether a Covered Service is Medically Necessary. Utilization Review involves review of medical records by a licensed physician or medical professional.